



# **Kansas Health Policy Authority Board**

## **Health Reform Recommendations**

### ***UPDATED***

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**PREPARED BY:**



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# EXECUTIVE SUMMARY

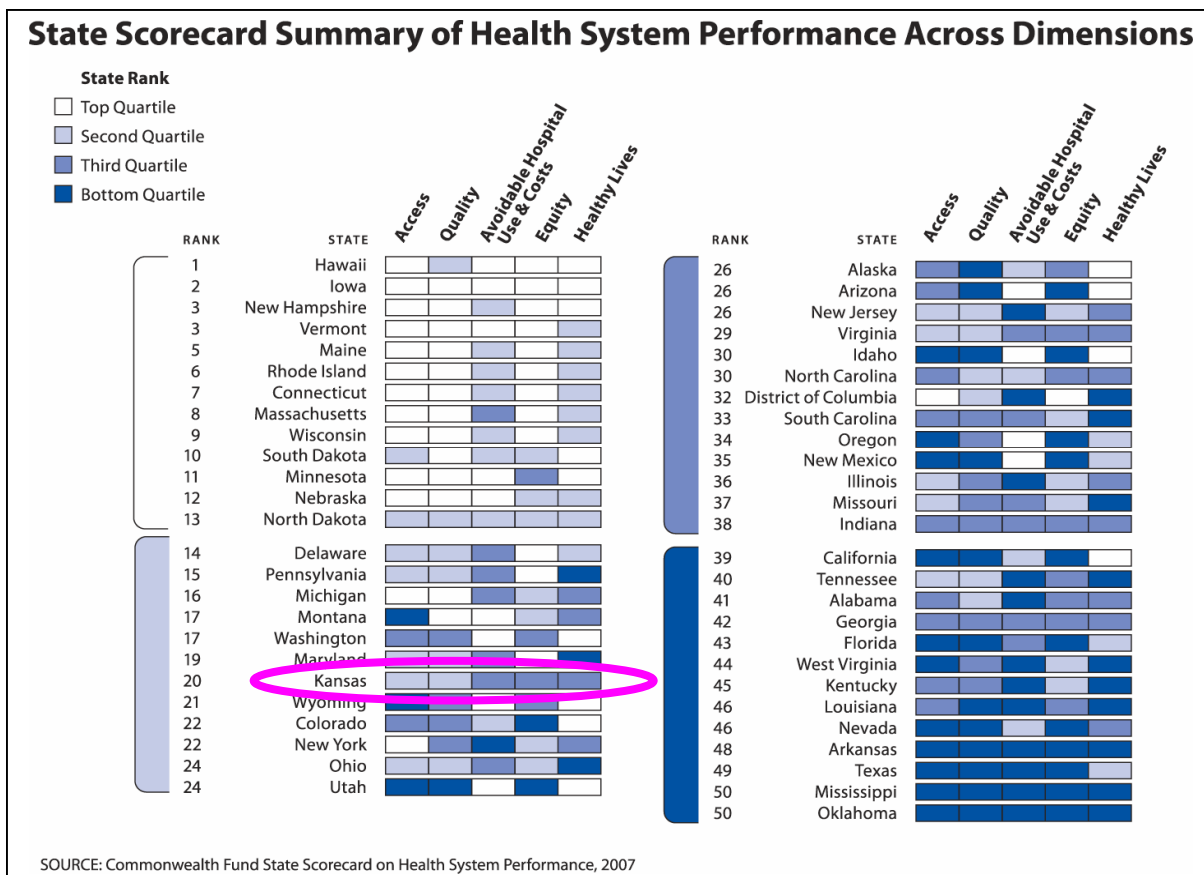
## BACKGROUND

The current health system in Kansas and the nation face many challenges. Health care costs continue to rise at an unsustainable rate, the health system is inefficient and fragmented, and the health status of many Kansans is at risk. From the perspective of health system performance, Kansas currently ranks 20<sup>th</sup> in the nation<sup>1</sup> – we can and should do better (Figure 1). The goals of the health reform recommendations described in this report are twofold: 1) to begin the *transformation* of our underlying health system in order to address the staggering rise in health care costs and chronic disease, as well as the underinvestment in the coordination of health care; and 2) to provide Kansans in need with affordable access to health insurance. Taken together, these reforms lay out a meaningful first step on the road to improve the health of Kansans, and we respectfully submit them to the Governor and Legislature for their consideration.

These health reform recommendations were requested by both the Governor and the Legislature. During the 2007 legislative session, the Kansas Legislature passed House Substitute for Senate Bill 11 (SB 11), which included a number of health reform initiatives. This Bill passed unanimously by both the House and Senate, and was signed into law by the Governor. In addition to creating a new “Premium Assistance program” to expand access to private health insurance, the Bill directed the Kansas Health Policy Authority (KHPA) to develop health reform options in collaboration with Kansas stakeholders.

The health reform recommendations described herein are the result of deliberations of the KHPA Board, four Advisory Councils (140 members), a 22 community listening tour, and feedback from numerous stakeholder groups and other concerned citizens of Kansas – over 1,000 Kansans provided us with their

Figure 1



\*For more information about the Study, go to [http://www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=494551](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=494551)





advice and suggestions. In addition, four Kansas foundations – the United Methodist Health Ministry, the Sunflower Foundation, the REACH Foundation, and the Health Care Foundation of Greater Kansas City – funded an independent actuarial and policy analysis of various health insurance models as well as the coordination of the four Advisory Councils. The modeling was instrumental in the development of the health insurance recommendations offered by the KHPA Board, and a separate document describing these models is available through the United Methodist Health Ministry Fund ([www.healthfund.org](http://www.healthfund.org)).

These health reform recommendations represent just one of the many chapters required to write the story of improved health and health care in Kansas. Ultimately, the solution for our fragmented health system requires leadership at the federal level. However, the state of Kansas should debate and embrace reform solutions that can help our citizens right now. Additional policy issues – such as health professions workforce development, and a focus on the safety and quality of care – must also be addressed in subsequent health reform proposals over the course of the coming months and years.

## PRIORITIES

Kansas established three priorities for health reform:

- 1) **Promoting Personal Responsibility** – for healthy behaviors, informed use of health care services, and sharing financial responsibility for the cost of health care;
- 2) **Promoting Medical Homes and Paying for Prevention** – to improve the coordination of health care services, prevent disease before it starts, and contain the rising costs of health care; and
- 3) **Providing and Protecting Affordable Health Insurance** – to help those Kansans most in need gain access to affordable health insurance.

The combination of these health reforms helps to improve the health status of Kansans, begins to contain the rising cost of health care in our state, and improves access to affordable health insurance.

The table below outlines the reform priorities recommended by the KHPA Board on November 1, 2007. Those policy initiatives identified as high priority are marked by an asterisk.

## SUMMARY OF REFORM RECOMMENDATIONS

Promoting Personal Responsibility (P1)		
Policy Option	Population Served	Estimated Cost
<b>Improve Health Behaviors.</b> Encourage healthy behaviors by individuals, in families, communities, schools, and workplaces. <b>(Policies listed under P2)</b>		
<b>Informed Use of Health Services</b>		
<b>*P1 (1) Transparency for Consumers: Health Care Cost &amp; Quality Transparency Project.</b> Collect and publicize Kansas specific health care quality and cost information measures which will be developed for use by purchasers and consumers	All Kansans with access to the Internet (or access to public libraries)	\$200,000 State General Fund (SGF) for Phase II of the Transparency project
<b>*P1 (2) Promote Health Literacy.</b> Provide payment incentives to Medicaid/HealthWave providers who adopt health literacy in their practice settings	Medicaid/HealthWave enrollees under care of these providers	\$280,000 All Funds (AF) \$140,000 SGF for pilot program with Medicaid/ HealthWave providers
<b>Shared Financial Responsibility.</b> Asking all Kansans to contribute to the cost of health care. <b>(Policies listed under P3)</b>		
<b>Estimated Costs for P1</b>	<b>\$480,000 AF \$340,000 SGF</b>	



Promoting Medical Homes and Paying for Prevention (P2)		
Policy Option	Population Served	Estimated Cost
<b>Promoting Medical Homes</b>		
<b>*P2 (1) Define Medical Home.</b> Develop statutory/regulatory definition of medical home for state-funded health programs – Medicaid, HealthWave, State Employee Health Plan (SEHP)	Beneficiaries of state-funded health care plans	Planning process should incur minimal costs to KHPA
<b>*P2 (2) An Analysis of and Increase in Medicaid Provider Reimbursement.</b> Increased Medicaid/HealthWave reimbursement for primary care and prevention services	Beneficiaries and providers in Medicaid and HealthWave programs	\$10 million AF; \$4 million SGF
<b>P2 (3) Implement Statewide Community Health Record (CHR).</b> Design statewide CHR to promote efficiency, coordination, and exchange of health information for state-funded health programs (Medicaid, HealthWave, SEHP)	Beneficiaries of state-funded health care plans	\$1.8 million AF; \$892,460 SGF
<b>P2 (4) Promote Insurance Card Standardization.</b> Promote and adopt recommendations from Advanced ID Card Project for state-funded health programs	Kansans who qualify/enrolled in state-funded health care plans	\$172,000 AF; \$86,000 SGF
<b>Paying for Prevention: Healthy Behaviors in Families/Communities</b>		
<b>*P2 (5) Increase Tobacco User Fee.</b> Institute an increase in the tobacco user fee \$.50 per pack of cigarettes, and an increase in the tax rate of other tobacco products to 57% of wholesale price.	Total Kansas population	Provides revenues of \$61.57 million. Dept of Revenue estimate 12/07
<b>*P2 (6) Statewide Restriction on Smoking in Public Places.</b> Enact statewide smoking ban in public places, couples with Governor's Executive Order requiring state agencies to hold meetings in smoke-free facilities	1.4 million working adults in Kansas	No cost to the state; limited evidence of other cost implications
<b>*P2 (7) Partner with Community Organizations.</b> Expand the volume of community-based health and wellness programs through partnerships between state agencies and community organizations	All residents and visitors to state of Kansas	Costs dependent upon scope of project (number of organizations)
<b>Paying for Prevention: Healthy Behaviors in Schools</b>		
<b>*P2 (8) Include Commissioner of Education on KHPA Board.</b> Expand the KHPA Board to include an ex-officio seat for the Kansas Commissioner of Education	Kansas school children	No cost
<b>*P2 (9) Collect Information on Health/Fitness of Kansas School Children.</b> Support the establishment of a state-based surveillance system to monitor trends of overweight, obesity, and fitness status on all public school-aged children in Kansas	Kansas school children K-12; for 2006-07 year, there were 465,135 enrolled K-12 students	Schools would incur some indirect costs for staff training and body mass index (BMI) measurement



Promoting Medical Homes and Paying for Prevention (P2) (continued)		
Policy Option	Population Served	Estimated Cost
<b><i>Paying for Prevention: Healthy Behaviors in Schools</i></b>		
<b>*P2 (10) Promote Healthy Food Choices in Schools.</b> Adopt policies that encourage Kansas school children to select healthy food choices by competitively pricing and marketing these foods and restricting access to foods with little or no nutritional value	Kansas school children K-12; for 2006-07 year, there were 465,135 enrolled K-12 students	Depending on pricing policies, implementation of this initiative may reduce or increase the revenue generated
<b>*P2 (11) Increase Physical Fitness and School Health Programs.</b> Strengthen physical education (PE) requirements and expand Coordinated School Health (CSH) programs	465,135 enrolled K-12 students	\$8,500 per participating school. KDHE has requested \$1.8 million SGF for the CSH program for participation of 100 districts
<b><i>Paying for Prevention: Healthy Behaviors in Workplace</i></b>		
<b>*P2 (12) Wellness Grant Program for Small Business.</b> Develop a community grant program to provide technical assistance and start-up funds to small businesses to assist them in the development of workplace wellness programs	Kansas employees of small firms	\$100,000 SGF for pilot project
<b>*P2 (13) Healthier Food Options for State Employees.</b> Expand healthy food choices in state agency cafeterias and vending machines	Approximately 45,000 state employees	Costs depend on contract negotiations and pricing policies
<b><i>Paying for Prevention: Additional Prevention Options</i></b>		
<b>*P2 (14) Provide Dental Care for Pregnant Women.</b> Include coverage of dental health services for pregnant women in the Kansas Medicaid program	6,600 Pregnant women enrolled in Medicaid	\$1.3 million AF; \$524,000 SGF
<b>*P2 (15) Improve Tobacco Cessation within Medicaid.</b> Improve access to Tobacco Cessation programs in the KS Medicaid program to reduce tobacco use, improve health outcomes, and decrease health care costs	Approximately 84,000 Medicaid beneficiaries who smoke	\$500,000 AF; \$200,000 SGF for an annual cost
<b>*P2 (16) Expand Cancer Screenings.</b> Increase screenings for breast, cervical, prostate, and colon cancer through expansion of the Early Detection Works (EDW) program	7,500 women (for Breast/Cervical screenings); 6,100 men (for prostate cancer screening); and 12,000 Kansans (for colorectal cancer screenings)	KDHE has requested \$6.7 million SGF for cost of expansion of all three cancer screenings
<b>Estimated Costs for P2</b> <div> <div>\$22.4 million AF</div> <div>\$14.3 million SGF</div> </div>		



Providing and Protecting Affordable Health Insurance (P3)		
Policy Option	Population Served	Estimated Cost
<b>*P3 (1) Access to Care for Kansas Children and Young Adults</b>		
<ul style="list-style-type: none"> <li>Aggressive targeting and enrollment of children eligible for Medicaid and HealthWave</li> <li>Include specific targets and timelines for improved enrollment. Inability to meet targets will “trigger” additional action by the KHPA, to include the consideration of mandating that all children in Kansas have health insurance</li> <li>Allow parents to keep young adults (through age 25 years) on their family insurance plan</li> <li>Develop Young Adult policies with limited benefit package and lower premiums</li> </ul>	Estimated 20,000 Medicaid/HealthWave eligible  Estimated 15,000 young adults	\$22 million AF \$14 million SGF
<b>*P3 (2) Expanding Insurance for Low-Income Kansans**</b>		
<ul style="list-style-type: none"> <li>Expansion population for the Premium Assistance program               <ul style="list-style-type: none"> <li>Adults (without children) earning up to \$10,210 annually[100% federal poverty level (FPL)]</li> </ul> </li> </ul>	Estimated 39,000 low income Kansas adults	\$119 million AF \$ 56 million SGF
<b>*P3 (3) Affordable Coverage for Small Businesses</b>		
<ul style="list-style-type: none"> <li>Encourage Section 125 plans (develop Section 125 “toolkits”) and education campaign for tax-preferred health insurance premiums</li> <li>Develop a “voluntary health insurance clearinghouse” to provide on-line information about health insurance and Section 125 plans for small businesses and their employees</li> <li>Add sole proprietors and reinsurance to the very small group market (VSG: one to ten employees). Stabilize and lower health insurance rates for the smallest (and newest) businesses: obtain grant funding for further analysis</li> <li>Pilot projects – support grant program in the Department of Commerce for small business health insurance innovations</li> </ul>	Estimated 12,000 small business owners and their employees  (***)Note: At the person level, the uncompensated care costs for the previously uninsured are reduced due to this change, hence the reduction in All Funds shown above. Practically, however, at the program level, the State of Kansas will not change the State’s Disproportionate Share Hospital reimbursement methodology.)	-\$5 million AF*** \$1 million SGF
<b>Estimated Costs for P3</b> Cost of all 3 policy options is:		
		<b>\$136 million AF</b> <b>\$ 71 million SGF</b>
<b>Total Costs</b>		<b>\$158.9 million AF**</b> <b>\$ 85.7 million SGF</b> <b>** (includes federal matching dollars)</b>

\*\*Two additional components of health reform, separate from the policies listed here, are being submitted to the Governor and Legislature as part of the KHPA budget. Funding for each is essential as the “building blocks” of health reform: 1) **Premium Assistance**. As designed in SB 11, this request asks for a \$5.037 million enhancement (\$12.075 AF) for the Premium Assistance program in FY2009; these funds will provide private health insurance to parents of children

eligible for Medicaid who earn less than 50% of the FPL (approximately \$10,000 for a family of four); and 2) **Web-Based Enrollment System**. The KHPA budget asks for a \$4 million enhancement for FY 2009 (\$8 million AF) to implement a new electronic eligibility system that can support premium assistance, enhanced outreach, and program participation through web-based enrollment.



# PROMOTING PERSONAL RESPONSIBILITY (P1)

## BACKGROUND

One of the three KHPA goals for health reform in Kansas is Promoting Personal Responsibility for health. Underlying this goal is the need for fundamental health system change to facilitate a person's active engagement in maintaining and improving his/her health regardless of age or health status. Achieving optimal health/wellness requires that individuals have greater access to health promotion/wellness interventions, useful health information, and shared financial responsibility for their health care expenditures.

- **Informed Use of Health Care Services:** Policy options designed to improve the informed use of health care services include: 1) expanding access to consumers regarding health care services, cost, and quality, and 2) a focus on improving health literacy.
- **Improved Health Behaviors:** Policy options designed to increase Kansans' accessibility to health promotion/wellness interventions in families and communities, schools, and the workplace are described under the second KHPA Health Reform goal of Promoting Medical Homes and Paying for Prevention.
- **Shared Financial Responsibility:** Policy options consistent with shared financial responsibility for consumers, providers, purchasers, and government are included under the Providing and Protecting Affordable Health Insurance.

## Background on the Consumer Health Care Cost and Quality Transparency<sup>2</sup>

Consumers deserve to know the quality and cost of their health care. For every other purchase that they make, consumers can easily get information about price and quality. When consumers have this information they can make better decisions. Consumers should share in the savings, in the form of lower premiums and more effective care, when they take an active role in health care decisions.

Health care transparency provides consumers with the information necessary, and the incentive, to choose health care providers based on value. Providing reliable cost and quality information empowers consumer choice. Consumer choice creates incen-

tives at all levels, and motivates the entire system to provide better care for less money. Improvements will come as providers can see how their practice compares to others. Transparency is a broad-scale initiative enabling consumers to compare the quality and price of health care services so they can make informed choices among doctors and hospitals. A Kansas Consumer Health Care Cost and Quality Transparency Project is currently underway which will begin to collect and make available existing health and health care data resources to the Kansas consumer. This initiative is further described under the policy option that seeks to implement the next phase of the project.

## Background on Health Literacy<sup>3</sup>

Health literacy is defined in *Health People 2010* as: "The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions." According to the American Medical Association, poor health literacy is "a stronger predictor of a person's health than age, income, employment status, education level, and race" (Report on the Council of Scientific Affairs, Ad Hoc Committee on Health Literacy for the Council on Scientific Affairs, American Medical Association, *JAMA*, Feb 10, 1999). In *Health Literacy: A Prescription to End Confusion*<sup>4</sup>, the Institute of Medicine reports that 90 million people in the US, nearly half the population, have difficulty understanding and using health information. As a result, patients often take medicines on erratic schedules, miss follow-up appointments, and do not understand instructions like "take on an empty stomach".

Health literacy varies by context and setting and is not necessarily related to years of education or general reading ability. A person who functions adequately at home or work may have marginal or inadequate literacy in a health care environment. With the move towards a more "consumer-centric" health care system as part of an overall effort to improve the quality of health care and to reduce health care costs, individuals need to take an even more active role in health care related decisions. To accomplish this, people need strong health information skills.



*"We need to have a renewed focus on personal responsibility of health care. We cannot have a solution until we change our culture of miracle medicines."*

Kansas City Chamber of  
Commerce Member

## POLICY OPTIONS

Two policy options designed to promote the informed use of health care services by Kansans are described in more detail:

- **Transparency for Consumers:** Consumer Health Care Cost and Quality Transparency Project: Collect and publicize Kansas specific health care quality and cost information measures for use by purchasers and consumers.
- **Promote Health Literacy:** Provide payment incentives to Medicaid/HealthWave providers who adopt health literacy enhancement initiatives in their practice settings.

### **P1 (1) Informed Use of Health Services: Transparency for Consumers: Consumer Health Care Cost and Quality Transparency Project**

## POLICY

Support the second phase of the Kansas Consumer Health Care Cost and Quality Transparency Project which will begin to collect and make available existing health and health care data resources to the Kansas consumer.

## BACKGROUND

In FY2008, KHPA approved a two-phase Health Information Transparency (HIT) Initiative for consumers. In Phase I of this project, the State Library of Kansas is working with other libraries to create a web-based portal of existing health and health care resources for Kansas consumers. Access to this information will be available from the KHPA website and through the libraries. The Health Transparency Portal will be marketed to all public libraries in Kansas as "the icon for health care" and training in the use of the Portal will commence after January 1, 2008. The development of the Portal has begun and will

be functionally implemented by January 15, 2008 and fully implemented by June 2008. A health information curriculum will also be established to educate Kansans about the use of health information and available health resources.

In Phase II of this Project, Kansas-specific health quality and cost measures recommended to the KHPA Board by the Data Consortium (which consists of health care stakeholders in Kansas) will be developed and made available to consumers through the Health Transparency Portal, allowing consumers to compare cost and quality of health providers and plans.

## KANSAS-SPECIFIC DATA

There are 327 public libraries located across the state of Kansas. The public library system is regionalized into seven districts — Central, North Central, Northeast, Northwest, South Central, Southeast, and Southwest. The public libraries have long served as a focal point in the community for information exchange. Simultaneously, the National Library of Medicine is developing a "Go-Local" feature, which brings information about local health care services and support groups to Kansas consumers. The Go-Local feature of this project will localize resources pertinent to the seven library districts.

## STAKEHOLDER INPUT

Many members of the KHPA Advisory Councils and other interested stakeholders commented on the need for health care cost and quality information. Through the Data Consortium, Kansas providers, consumers, researchers, and other stakeholders will play a significant role in developing the indicators used for this public reporting.

## POPULATION SERVED

The population served is all Kansans with access to the Internet or public libraries. The entire population of the state (2,764,075) has access to the public libraries in their community or communities nearby.

## ESTIMATED COST

The cost of \$200,000 is needed for implementation of Phase II of the Kansas Consumer Health





Care Cost and Quality Transparency Project. These funds will be utilized to continue the employment of the librarian dedicated to the project, maintain the authentication software allowing Kansans to access copy-written materials, provide grants to local libraries, market the program, and integrate the health quality and cost data.

## **P1 (2) Promoting Informed Use of Health Services: Improving Health Literacy**

### **POLICY**

Establish a pilot program to provide payment incentives to Medicaid/HealthWave providers who adopt health literacy enhancement initiatives in their practice settings.

### **BACKGROUND**

An informed purchase of health care services requires health literacy by the consumer. Health literacy is the skill set required for an individual to gain access to and understand and use information in ways which promote and maintain good health. The health care system needs to improve consumers' access to health information and their capacity to use it effectively.

Nearly half of all adults have a health literacy problem. Consumers with limited literacy skills have less knowledge about, and poorer adherence to, medication and self-care regimens for certain chronic conditions; have less knowledge and less likelihood of getting specific preventive tests and exams; have poorer self-reported health and poorer health outcomes; and have increased hospitalizations and costs.

A large gap exists between the health literacy level of people and much of the health information produced by the health care industry, creating a situation where many consumers cannot understand the health information they receive from providers. In 1998, inadequate health literacy cost the US health system an estimated \$30-\$73 billion. A small number of states have specific projects focused on health literacy, but these initiatives are in their infancy and much more needs to be done if consumers are to achieve optimal health, particularly if they are living with chronic disease.

As part of a 2002 Council of State Governments (CSG) comprehensive study of health literacy, researchers identified "best practice" models, including the development of adult and school-age health literacy toolkits. The Kansas Consumer Health Care Cost and Quality Transparency Project will include a curriculum and toolkits for both adults and children to improve health literacy designed by the University of Kansas Medical Center and state librarians.

### **KANSAS-SPECIFIC DATA**

A 2007 survey by Health Literacy Innovations of Medicaid agencies indicated that Kansas was among 56% of states who had set readability guidelines for their Medicaid materials at a 6<sup>th</sup> grade reading level.

### **STAKEHOLDER INPUT**

Multiple Advisory Council members mentioned the health literacy issue and the need for useable health information. Organizations, such as the Kansas Chapter of the American Academy of Pediatrics, are focusing on the issue of health literacy. With a \$1 million challenge grant from the Kansas Health Foundation (KHF), they are designing a statewide early literacy program – "Turn a Page. Touch a Mind," – which can be highlighted as part of the pilot project.

### **POPULATION SERVED**

The population served is Medicaid/HealthWave enrollees who are under the care of providers adopting the health literacy enhancement strategies.

### **ESTIMATED COST**

The cost will be \$280,000 AF and \$140,000 SGF to establish a pilot program that provides financial incentives to Medicaid/HealthWave providers who adopt health literacy enhancement initiatives.



# PROMOTING MEDICAL HOMES AND PAYING FOR PREVENTION (P2)

## BACKGROUND OF THE MEDICAL HOME CONCEPT<sup>1</sup>

Many Americans may not be familiar with the term "medical home;" however, they know when they do not have one – that is, a primary care practice that provides them with accessible, continuous, and coordinated care. A medical home is more than just a place; it is a comprehensive approach to providing care. The idea of a medical home is 180 degrees from an emergency room, urgent care facility, or walk-in clinic. In medical home practices, patients develop relationships with their providers and work with them to maintain healthy lifestyles and coordinate preventive and ongoing health services. In this sense, medical homes are the foundation of patient-centered care, designated by the Institute of Medicine as one of the six aims for the health care system, and defined as care that is respectful of, and responsive to, individual patient preferences, needs, and values<sup>5</sup>.

The concept of a medical home began with pediatricians, who see children frequently during their early years and, thus, have opportunities to provide comprehensive care, including developmental and behavioral services. In 1977, the American Academy of Pediatrics (AAP) adopted a policy statement which declared that "quality medical care is also best provided when all of the child's medical data are together in one place (a medical home) readily accessible to the responsible physician or physicians." The AAP has fleshed out this concept over the years. In 2002, it described the concrete attributes of a medical home; for example, defining "accessible" care as care that is physically and financially within reach of patients, but which is also facilitated by effective patient-provider communication. "Comprehensive" care, they maintained, should extend beyond basic medical care to include educational, developmental, psychosocial, and other individual needs.

Many experts argue that medical homes are important for all patients, not just children and adolescents. As part of broader quality improvement efforts, medical homes could ensure the provision of appropriate preventive services, help patients manage their chronic conditions, and reduce spending on emer-

gency or other acute care. Nurses would play central roles, working with primary care physicians to develop disease management programs for patients with chronic illnesses and provide support for all patients in their efforts to live healthy, productive lives. In Kansas, coordination of care for adults and children is slightly better than the average state, but with an increased focus on medical homes, health outcomes could be improved<sup>6</sup> (Figure 2).

In its 2002 policy statement, the AAP expanded the medical home concept to include these operational characteristics – accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care. The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) have since developed their own models for improving patient care called the "medical home" (AAFP, 2004) or "advanced medical home" (ACP, 2006). The "Joint Principles for a Medical Home" were established by the AAFP, the AAP, the ACP, and the American Osteopathic Association (AOA) in Feb. 2007.

## POLICY OPTIONS

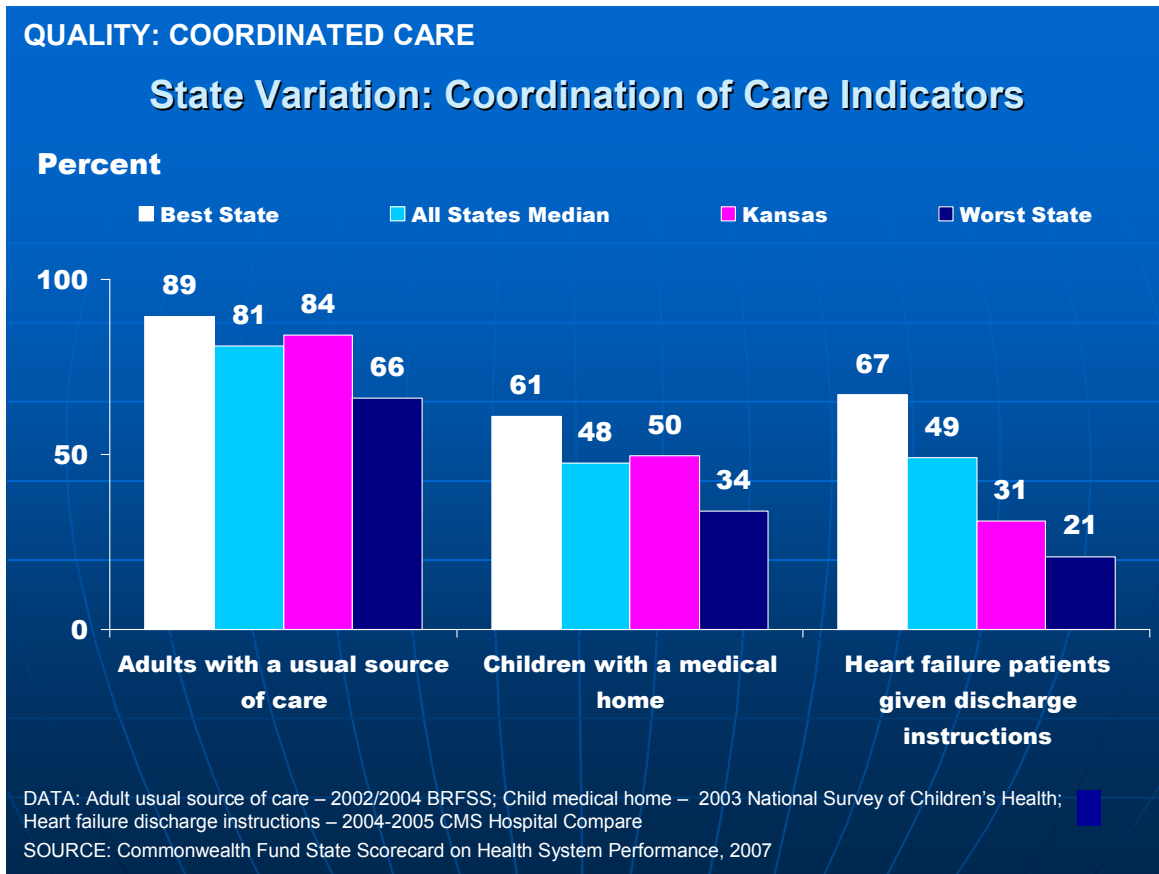
A number of policy options associated with the development of person-centered medical homes in Kansas are described in more detail. They are summarized below:

- Defining a medical home in statute or regulation, and encouraging Medicaid/HealthWave beneficiaries to select a medical home for primary care services,
- Increased Medicaid/HealthWave reimbursement for primary care services consistent with a medical home and "value-based health care",
- Development and promotion of a statewide CHR for Medicaid/HealthWave and the SEHP, and
- Adopt recommendations from Advanced ID Card Project for Medicaid/HealthWave beneficiaries and for the SEHP.





**Figure 2**



**P2 (1) Promoting Medical Homes: Defining a Medical Home in Statute**

**POLICY**

Develop a statutory or regulatory definition of a medical home for state-funded health programs (Medicaid/HealthWave and the SEHP).

**BACKGROUND**

One of the components of Kansas health reform is to promote a person-centered medical home as a way to improve the quality of primary health care, promote improved health status, and ultimately help to control the rising costs of health care. The designation of the medical home is a cornerstone of support for other areas of the KHPA preventive health agenda. Defining in statute the meaning of a medical home in Kansas will provide the framework for further development and implementation of a medical home model.

Promoting the development and use of medical home practices will help to organize health care services through a medical home model with the goal of improving health outcomes and containing health care costs. States, such as Colorado, Washington, Missouri, and Louisiana, are advancing the medical home model and passing legislation to organize Medicaid programs around the medical home concept. North Carolina has used existing legislative authority to extend the medical home concept to its Medicaid and State Children's Health Insurance Program (SCHIP) populations. A number of states have defined a medical home in statute, such as Louisiana, Colorado, and Massachusetts.

The medical home in Kansas should recognize the importance of mental health services and the relationship between physical and mental health. In addition, addressing the appropriate services and continuum of care over the life span is critical to the medical home, which should include a focus on improvement on end-of-life care.



## STAKEHOLDER INPUT

In order to determine the appropriate definition of a medical home for state-funded health programs (Medicaid/HealthWave and the SEHP), a process should be developed to include stakeholder input. The support of a medical home has been endorsed by the AAFP, the AAP, the ACP, and the AOA. The Kansas chapters of these organizations are also supportive of a medical home model. As part of the stakeholder process moving forward, additional stakeholder feedback should be solicited from various health care practitioners, such as nurse practitioners and physician assistants, rural health clinics and safety net health care clinics, and organizations with specific expertise in various aspects of the continuum of care. Expanding the person-center medical home will require partnership with mid-level practitioners and safety net clinics, which are critical to serving the needs of rural communities and underserved areas in Kansas.

## POPULATION SERVED

The population served are all beneficiaries of state-funded health care plans (Medicaid/HealthWave and the SEHP), as well as Kansas health care providers.

## ESTIMATED COST

The planning process should incur minimal costs to the KHPA. Costs associated with reimbursement for the medical home model are not considered here.

### P2 (2) Promoting Medical Homes: Increase Medicaid Provider Reimbursement

## POLICY

Analyze and increase specific reimbursement for primary care services consistent with a medical home model and “value-based health care purchasing” for the Kansas Medicaid/HealthWave program.

## BACKGROUND

The concept of value-based health care purchasing is that purchasers should focus on outcomes, cost, and quality of health care through the informed use of health care services. In Kansas, value-based purchas-

ing can focus on incentives for health services delivered through a primary care medical home, thus, reducing inappropriate and inefficient care. The health care system and its patterns of reimbursement currently serve as disincentives for providers to take time to provide those preventive services not associated with a technical procedure. Even those technical procedures associated with prevention activities are often not paid for at the optimal rates. Health care reform should include a commitment to analyze the reimbursement rates of health providers serving beneficiaries of state-funded health plans for a wide range of screening activities and preventive care.

## KANSAS SPECIFIC DATA

Increased reimbursement for primary care preventive services is key. On average, physicians serving Medicaid beneficiaries are reimbursed at 83% of the maximum allowable Medicare rate. However, many of the services for prevention are reimbursed at less than half of Medicare reimbursement rates. This proposal would include a review of reimbursement for primary care preventive services, including well-child visits, immunizations, disease screening, and other clinical procedures linked to Current Procedural Terminology (CPT) and Health Care Procedural Services (HPCS) codes. Providing maximal reimbursement for current codes, and recognizing and reimbursing new and needed preventive service codes, will drive health care professionals to provide more preventive care.

In 2008, the Kansas SEHP is moving toward value-based purchasing with a focus on “first dollar coverage” for preventive services and annual wellness exams, as well as a significant investment in health promotion through incentives aimed at self-engagement in health and wellness activities. This

*“It’s difficult for a provider to code for Medicaid for obesity counseling. Insurance won’t pay for it. They pay for the diabetes but not the counseling. And so people won’t come to the doctor until they have the chronic disease because they have to pay the doctor bill themselves.”*

Emporia Provider at Flint Hills  
Community Health Center



includes reimbursement for telemedicine to increase access to care for rural Kansans. Additional improvements in the SEHP for next year will include incentives for providers to deliver health services consistent with a primary care medical home. Using the SEHP as a model, the Kansas Medicaid/HealthWave program will build in appropriate incentives for prevention, wellness, and the use of medical homes.

## STAKEHOLDER INPUT

The support of a medical home has been endorsed by the AAFP, the AAP, the ACP, and the AOA. The Kansas chapters of these organizations are also supportive of a medical home model that better reimburses for the cost of primary and preventive care, as are other provider and consumer advocate organizations.

## POPULATION SERVED

The populations served are beneficiaries and health care providers in the Kansas Medicaid/HealthWave program.

## ESTIMATED COST

Although costs will depend upon the number of CPT codes, which are procedure codes for outpatient services that are increased, (assuming that the reimbursement rate will mirror Medicare CPT code reimbursement), we estimate approximately \$4 million SGF/\$10 million AF will be needed to support increases in reimbursement.

### P2 (3) Promoting Medical Homes: Implementation Statewide Community Health Record (CHR)

## POLICY

Design a statewide CHR to promote the coordination and exchange of health information for state-funded health programs (Medicaid/HealthWave and the SEHP).

## BACKGROUND

Improving the coordination of health care is a key component of a medical home model and the utiliza-

tion of health information technology is a primary means to improve coordination. The clinical care of state-funded health plan beneficiaries is fragmented between different providers, clinics, and other health care facilities. This fragmentation leads to discontinuities in care related to lack of effective information exchange and significant inefficiency in the health care system. Similar difficulties exist in the transmission of health plan eligibility and benefit information.

Promoting a statewide exchange of clinical and financial health care information can improve efficiency, enhance the process of health care delivery, and promote patient safety. Moreover, as one of the largest payers of health care services in the state, we would leverage our considerable purchasing power to promote the use of health information technology and exchange through a statewide CHR.

Improving access to personal health information by consumers will also help to promote self-management of care and personal responsibility. A statewide CHR in Kansas should integrate consumer access to allow consumers to review their personal health information (PHI) to further promote personal responsibility and self-management of care. As such, ensuring consumer privacy and security must be a key consideration in the development of health information exchange, and consumers must be given ultimate authority in who is allowed to view their health information.

Nearly two years ago, the state of Kansas implemented a pilot project to use a CHR to help deliver timely and accurate health information for Medicaid beneficiaries. The current CHR pilot project is built on administrative claims data (from health plans) and provides clinicians electronic access to claimed medical visits, procedures, diagnoses, medications, demographics, allergies and sensitivities, immunizations, vital signs, and lead screening and health maintenance data (includes Early and Periodic Screening, Diagnosis and Treatment [EPSDT] status). The record also contains an e-Prescribing component that enhances the clinician's workflow, reduces the risk of medication error caused by inadequate or unavailable patient information, and increases safety and health outcomes associated with prescription generation.



## KANSAS SPECIFIC DATA

In Kansas, approximately 21% of physician offices use electronic clinical information. In the hospital environment, 51% reported access to electronic lab results, 34% reported electronic imaging systems in place, and 24% reported electronic medication administration.

## STAKEHOLDER INPUT

Evaluations from health care providers who utilized the CHR in Sedgwick County were very positive about the utility of the CHR. The development and implementation of a statewide CHR would require significant stakeholder input. Accordingly, the KHPA Board should create a “Health Information Technology/Health Information Exchange/” (HIT/HIE) Advisory Council” to provide ongoing feedback about the development and implementation of a statewide CHR taking into account the work of the Governor’s Health Care Cost Containment Commission, the Health Information Exchange Commission, and the Kansas Health Information Security and Privacy Collaboration (HISPC) project. The HIT/HIE Advisory Council could also provide guidance on the means to provide education and technical support for health care providers interested in integrating health information technology into their practices. Consumer and provider input to this process will be critical.

## POPULATION SERVED

The population served are all beneficiaries of state-funded health care plans (Medicaid/HealthWave and the SEHP), as well as Kansas health care providers.

## ESTIMATED COST

Costs are approximately \$1.8 million AF or \$892,460 SGF for full statewide implementation of the CHR. Because a CHR is web-based, health providers are not required to purchase expensive equipment or software technology to utilize a statewide CHR. Providers will require access to the Internet and be provided with training on the utilization of the CHR.

## P2. (4) Promoting Medical Homes: Promote Insurance Card Standardization

### POLICY

Include a standardized format for health insurance cards for Medicaid/HealthWave beneficiaries and for SEHP enrollees to decrease administrative costs, improve efficiency, and increase health care coordination.

### BACKGROUND

One-third of every health care dollar is spent on administrative costs, and a lack of standardized electronic health insurance cards is part of the reason. Most insured Kansans carry around one or more health insurance cards in their wallet. However, unlike debit cards, credit cards, or even grocery store discount cards, these health insurance cards are not electronic, which results in physician offices investing more time on paperwork, and resources diverted away from patient care. Improving the coordination of health care services will lower administrative costs and is a key component of a medical home.

A health insurance ID card is a patient’s entry point into the health care system. A study completed by the Governor’s Health Care Cost Containment Commission found that approximately 20% of claims were denied due to inaccurate or incomplete information about a patient’s coverage. Presently, ID card technology has advanced to the point that it can be used as a “key” for providers to unlock a patient’s financial and insurance eligibility information and reduce errors in claim denial. Not only will the new card save the administrative costs of processing denied claims, it will also make the patient’s registration process easier. This information could be accessed via the electronic cards, reducing claim denials that currently result in significant administrative costs for physicians, hospitals, and health plans – costs that are ultimately passed on to patients and employers.

For the Medicaid/HealthWave program, the KHPA currently issues paper ID cards monthly. Under this plan, the KHPA would substitute plastic “advanced ID cards” that utilize a magnetic stripe or bar code technology. These cards will allow a provider the ability to



instantly determine if a member qualifies for a Kansas Medical Assistance Program (KMAP) or future program, such as Premium Assistance, by swiping or scanning a patient's card. For the SEHP, the use of advanced ID cards will be required in future contracts with health plans.

## **STAKEHOLDER INPUT**

A diverse group of stakeholders representing multiple industries and entities, including health plans, physicians, medical office managers, practice management software companies, clearinghouse vendors, pharmacies, and ancillary providers have been actively meeting and collaborating on this project since September of 2006. The KHPA funded a project through the Mid-America Coalition on Health Care to develop a plastic card with advanced ID card technology. The collaboration through this project has helped to prepare stakeholders for the adoption of the advanced ID card. The format for the card is being developed using national standards that govern the transmission and receipt of information (C.O.R.E) and that focuses on the specifications of applying ID card technology to patient ID cards (WEDI). The idea of real-time eligibility that may some day lead to real-time payment and a decrease in claim rejections resonates well with providers.

## **POPULATION SERVED**

The population served is Kansans who qualify for Medicaid/HealthWave and state employees. Kansans participating in the SEHP will be affected as the KHPA renews contracts with health plans.

## **ESTIMATED COST**

The total costs (AF) to implement this program will total approximately \$172,000; \$86,000 of this cost is SGF.

It is estimated that the shift to the "advanced ID card" will result in a subsequent year savings of \$500,000 AF and \$250,000 SGF from the significant reduction in postage, production, and materials cost associated with mailing paper cards monthly.

## **BACKGROUND ON PAYING FOR PREVENTION<sup>7</sup>**

Progress in preventing and treating disease has added approximately 30 years to Americans' life expectancy since the beginning of the 20th century. For example, over the past 50 years, advances in the treatment of cardiovascular disease alone have added more than three years to the life expectancy of men and women. As Americans live longer, healthier lives, they also are working longer, thus, continuing their contributions to the economy. A one-year improvement in the life expectancy of the US population translates into an estimated 4% increase in gross domestic product (GDP) – an increase currently equal to about \$540 billion.

Yet, even as the US health system's ability to prevent and treat disease improves, the prevalence of chronic health problems among working Americans is rising. Indeed, the actual causes of death in 2000 are linked to behaviors that undermine health outcomes, such as tobacco use, poor diet and lack of exercise, and use of alcohol<sup>8</sup>. These behaviors lead to heart disease, cancer and stroke – the three leading causes of preventable death (Figure 3).

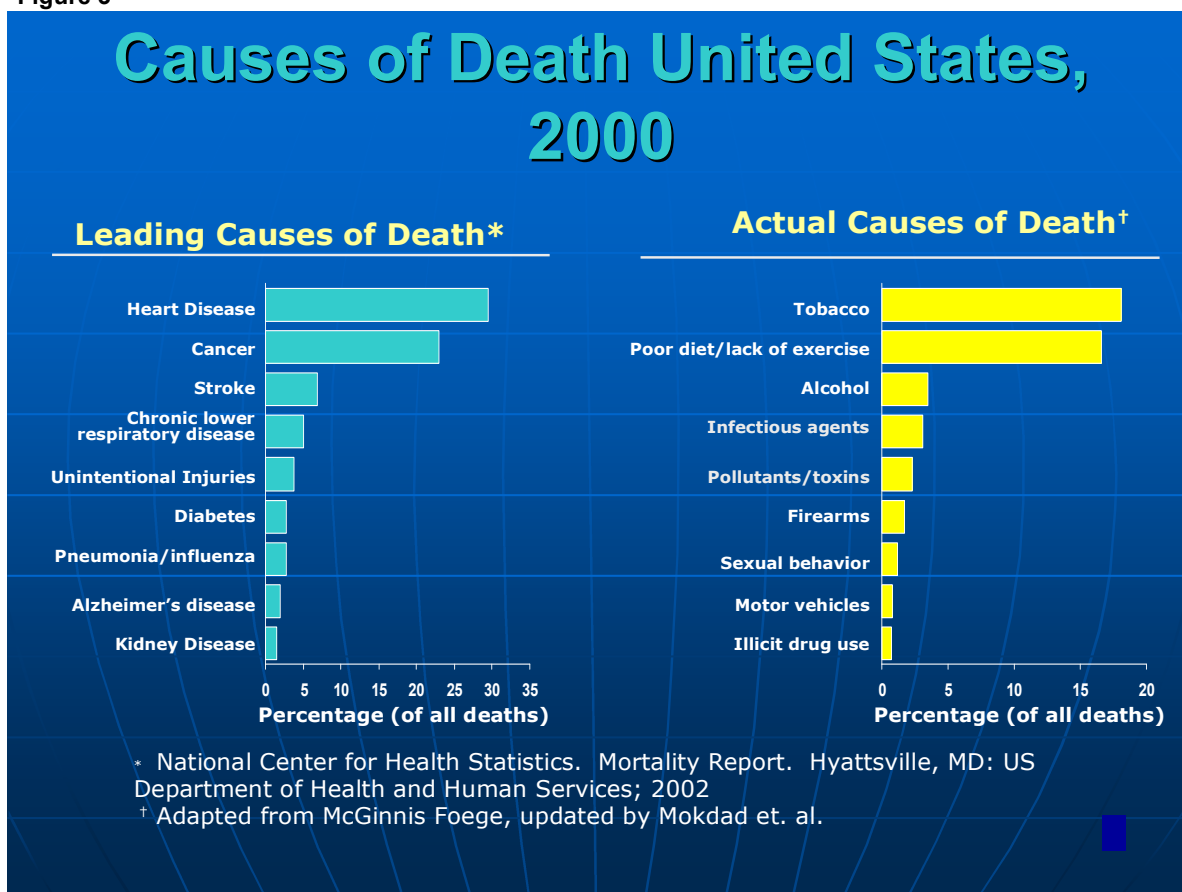
Individuals, of course, prefer to be healthy and productive rather than sick and unable to work. Yet, illness and chronic conditions can keep people out of work for days or even months at a time or force them to leave the workforce altogether. Inability to work diminishes individuals' quality of life and capacity to provide for themselves and their families. Being unable to work can lead not only to a loss of financial security, but also to reduced self esteem and symptoms of depression.

In addition, lost or unproductive work days pose a significant cost to national and local economies. For example, in Kansas, hypertension, asthma, and diabetes account for an estimated 1.2 million lost work days each year. This is the equivalent of \$280 million annually.

The incidence of chronic conditions among the working population is increasing. In 2003, three out of ten US workers reported having a health problem defined as presence of a chronic condition, such as diabetes, arthritis, cancer, or heart disease; presence of a disability; or self-reported fair or poor health status. These health conditions lead not only to missed work



Figure 3



time (absenteeism), but also reduced productivity while at work (referred to as “presenteeism”). An estimated 69 million workers took sick days in 2003, amounting to 407 million lost work days. This translates into \$48 billion in wages paid for time not worked because of illness.

Health behaviors affect health outcomes<sup>9</sup>. Individual behaviors like smoking or lack of physical activity leads to more chronic diseases and impacts all Kansans through rising health care costs (Figure 4). Kansas obesity rates have steadily increased over the last decade for adolescents and adults. Obesity contributes to a number of health problems, including diabetes and heart disease. In 2003, the percent of overweight and obese adults in Kansas was over 60%; the percent of Kansans determined to be obese was 24%, while 11% of children were overweight or obese. In addition to low consumption of fruits and vegetables, almost 26% of adult Kansans reported they did not participate in any leisure time physical activity. If this trend continues, by 2020, one out of four health care dollars will pay for obesity-related treatments.

In addition to health issues related to diet and physical activity, many Kansans continue to use tobacco. Twenty percent of adult Kansans smoke, which contributes to more than 4,000 deaths annually and more than \$190 million in total Medicaid expenditures. Strikingly, one in eight pregnant women residing in Kansas smoke, which results in poor birth outcomes and significant health care costs. The cost of health care has a direct correlation with chronic diseases; recent data indicate that nearly 80% of health care costs in Kansas are attributed to chronic diseases. As in other states, the number of Kansans who smoke and are overweight are far more likely to suffer from heart disease and cancer. Heart disease in Kansas continues to be the number one cause of death accounting for a quarter of all deaths, many of which are preventable. Cancer is the second leading cause of mortality and accounts for 22% of all deaths. An estimated 45% of men and 41% of women will be diagnosed with cancer during their lifetime. Currently, more than 95,000 Kansans live with cancer. The cost of battling and succumbing to cancer has a \$1.6 billion





*"The most pressing issue is people taking responsibility for living healthy lifestyles. It's not a health care crisis. It's a health crisis."*

Winfield Health Care Provider

annual impact on the Kansas economy – a cost of \$4.4 million per day. While the KHPA seeks to solve the problem of accessible health insurance and care, we must also look at making health care more affordable and promoting personal responsibility in the individual choices we make. Healthy lifestyle choices will lead to a Healthy Kansas.

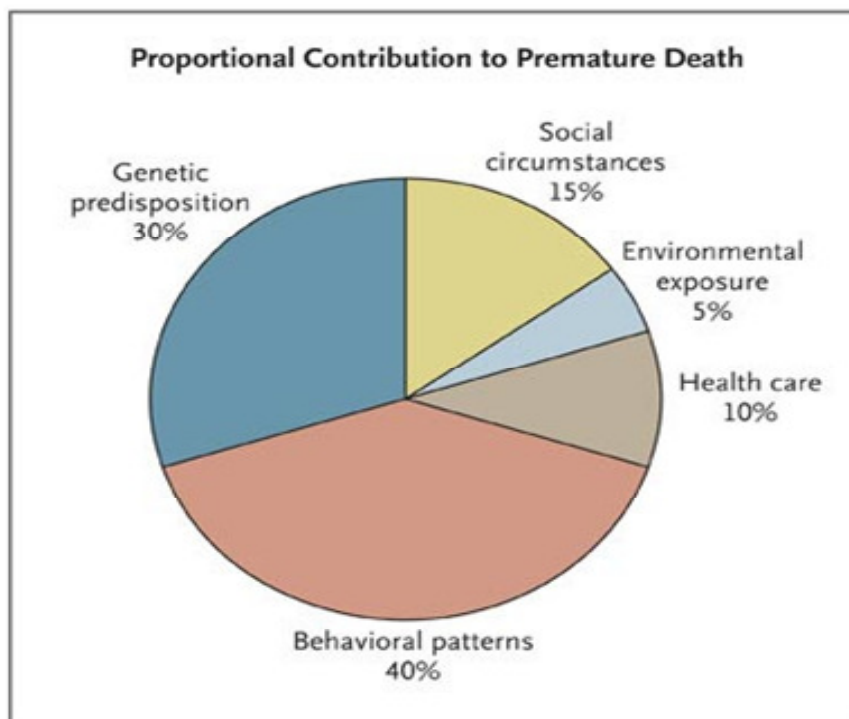
### POLICY OPTIONS

There are four sets of policy options aimed at paying for prevention and improving health outcomes.

- Improve healthy behaviors in families and communities
  - ◆ Increase tobacco user fee
  - ◆ Statewide ban on smoking in public places
  - ◆ Partner with community organizations
- Improve healthy behaviors in schools
  - ◆ Include Commissioner of Education on KHPA Board
  - ◆ Collect information on health/fitness of Kansas school children
  - ◆ Promote healthy food choices in schools
  - ◆ Increase physical fitness and school health programs
- Improve healthy behaviors in the workplace
  - ◆ Wellness grant program for small businesses
  - ◆ Healthier food options for state employees
- Additional prevention policies
  - ◆ Provide dental care for pregnant women on Medicaid
  - ◆ Improve tobacco cessation within Medicaid
  - ◆ Expand cancer screenings

Figure 4

## Determinants of Health Status



Source: Schroeder SA. N Engl J Med 2007;357:1221-1228



## **P2 (5) Improve Healthy Behaviors in Families and Communities: Increase Tobacco User Fee**

### **POLICY**

Institute an increase in the tobacco user fee. It is proposed that the current excise tax on cigarettes be raised \$.50 per pack and an increase in the tax rate of other tobacco products (chewing tobacco, snuff, dip, cigars, etc.) to 57% of the wholesale price.

### **BACKGROUND**

The burden of tobacco use in Kansas is great. Each year tobacco causes over 4,000 Kansas deaths, and generates nearly \$930 million in health care costs (\$196 million within the Medicaid program alone). Policy research has shown that raising the cost of tobacco products is an effective means to decrease the rates of tobacco use. A 10% increase in the price of a pack of cigarettes is associated with a 4% drop in tobacco use (in real terms, an increase of \$.50 per pack of cigarettes may result in 20,000 of the current 400,000 adult smokers in Kansas quitting). The effect is even more pronounced among price-sensitive teens, where a similar price rise results in a 7% reduction in smoking rates.

Fifty percent of tobacco smokers begin their tobacco use before the age of 14. Not only do the habits of adults begin in childhood, but tobacco also serves as a gateway to other substance use among youth. Children and adolescents consume more than one billion packs of cigarettes a year. An increase in the excise tax on tobacco products has been one of the most effective ways to discourage youth from starting to smoke. Such a policy not only serves as an effective deterrent to tobacco use, but as an acknowledge-

ment of the health costs that all Kansans incur as a result of usage.

Tobacco use is the leading cause of preventable deaths and health care costs. Increasing levels of imposed tobacco user fees have been demonstrated to decrease smoking rates, resulting in long-term savings in lives and costs. At the end of 2005, the average state excise tax on cigarettes was \$.922 per pack and by early 2007 that figure had risen to about \$1.03 per pack. Currently the excise tax on a pack of cigarettes in Kansas is \$.79 per pack. Tobacco use costs Kansans the equivalent of \$.86 per pack of cigarettes sold to pay for the tobacco-related illness of Medicaid recipients alone. However, Kansas currently collects only \$.79 per pack of cigarettes in health impact fees to offset this expenditure (KDHE). An increased excise tax on all tobacco products would both reduce the number of youth who take up smoking and diminish the annual \$930 million health care costs associated with tobacco consumption.

Similarly, increasing the state tax on non-cigarette tobacco products will raise new state revenues and help to reduce tobacco use levels, especially among youth, thereby reducing related harms and costs as well. Put simply, the increased revenues per package of each tobacco product sold brings in far more new revenue than are lost by the reduction in tobacco product consumption and sales prompted by the tax increase.

Over 9% of adult males in Kansas currently use chewing tobacco or snuff. In rural areas, prevalence is known to exceed 17%. Among high school males, nearly 1 in 10 report using chewing tobacco, snuff or dip and 2 in 10 report smoking cigars. These other tobacco products are currently taxed at a rate of 10% of wholesale price. To avoid making less-expensive other tobacco products a gateway to cigarette addiction or an alternative to quitting or cutting back for smokers, it is important that state tax rates on other tobacco products parallel the state's tax rate on cigarettes. For the state's current cigarette tax rate of \$.79 per pack, the comparable tax rate for other tobacco products would be approximately 35% of wholesale price.

### **STAKEHOLDER INPUT**

All three Advisory groups supported an increase in the tobacco tax; the Purchaser Advisory Council sup-

*"Everyone is in favor of a higher tax on tobacco. Smoking ban is the single most important thing we can do to improve health, making it as expensive as possible or limiting the locations that they are available to smoke."*

Consumer at Community Health Center of SE Kansas in Pittsburg





ported a tobacco tax increase if used as a dedicated and sustainable financing mechanism for health reform. A number of other advocacy organizations and provider organizations in Kansas support an increase in tobacco tax. In addition, in a recent poll, 64% of Kansas adults support an increase in tobacco user fees to decrease tobacco use regardless of the use of the additional fees (Sunflower Foundation Poll, 2007).

### POPULATION SERVED

The entire Kansas population, including the 20% who currently smoke, would benefit in a reduction of the \$930 million health care cost associated with tobacco consumption.

The 21% of high school students and 6% of middle school students who currently smoke would benefit from having a substantial barrier to smoking. The 9.3% of adult males and the nearly 20% of high school males who currently use some type of other tobacco products would benefit from a substantial barrier to using other tobacco products.

### ESTIMATED COST

The policy initiative incurs no cost to the State. An increase in the tobacco user fee of \$.50 per pack of cigarettes is expected to yield revenues of \$43.14 million in tax revenue per year with increases of 2.8% annually. This increase in the cigarette tax is projected to result in 7,800 fewer adult smokers, 15,800 fewer youth smokers, and a lifetime health savings for individuals currently alive of \$318.9 million. An increase in the excise tax on other tobacco products to 57% of wholesale price would generate approximately \$18.43 million in new revenue and reduce the number of youth users by nearly one-third. Revenues generated by the increased taxes on cigarettes and other tobacco products would be deposited in an interest bearing health reform trust fund.

**P2 (6) Improve Healthy Behaviors in Families and Communities: Enact a Statewide Restriction on Smoking in Public Places**

### POLICY

Enact a statewide smoking restriction in public places, coupled with a Governor's Executive Order requiring state agencies to hold meetings in smoke-free facilities will allow Kansans to work and gather without exposure to the negative consequences of secondhand smoke on their health.

### BACKGROUND

This policy option recommends that legislation be enacted that prohibits smoking in all public places. Based on the health impact on cities that have enacted strict clean indoor air laws, a statewide law in Kansas could result in 2,160 fewer heart attacks and \$21 million less in associated hospital charges for heart attacks alone. A recent poll indicated that 73% of Kansas adults favor such a state law or local ordinance.

Secondhand smoke is ingested in two ways: 1) through the lit end of the cigarette; and 2) by the exhaled smoke of the smoker. Cigarette smoke contains over 4,000 chemicals and is a known carcinogen. At its most severe impact, secondhand smoke results in 3,000 annual cancer deaths in the US and 35,000 deaths from heart disease. This statistic represents a stark consequence of secondhand smoke, but fails to show the full impact. Exposure to cigarette smoke also results in an increase of asthma attacks, lower respiratory tract infections in children under 18 months old, coughing, and reduced lung function. Pregnant women are particularly susceptible to having low birth weight babies as a result of secondhand smoke exposure. A 2006 Surgeon General's report notes that, "the scientific evidence indicates there is no risk-free level of exposure to secondhand smoke." The National Institute for Occupational Safety and Health (NIOSH) recommends that secondhand smoke be considered as a potential occupational carcinogen.

Enactment of smoke free policies at the state level would address the issue of business owners who believe that local control of smoking bans results in an uneven playing field as businesses compete with other jurisdictions that may have no ban in place. In Kansas, 72% of the working population is protected by worksite nonsmoking policies. (CDC Sustaining State Programs for Tobacco Control Data Highlights, 2006). More than 40 states have imposed restrictions on smoking in public places. (National Conference of State Legislatures 2004).



Smoking is the number one preventable cause of death in Kansas and 83% of Kansas adults believe it is a serious health hazard. (Sunflower Foundation 2007). Evidence has shown that statewide smoking bans decrease the smoking rate among active smokers by 10%, a potential decrease of 40,000 smokers in Kansas (KDHE).

## STAKEHOLDER INPUT

The Consumer Advisory Council supported a ban on smoking in public places; the Purchaser Advisory Council believes all sectors of government should be involved in adoption of public policies to decrease tobacco use because health plans and insurers are not the only answer, and the Provider Advisory Council supports creating healthy workplaces. In addition, the Kansas Hospital Association (KHA), although Kansas currently has a statute banning smoking in medical care facilities, would like to expand that ban to all hospital property.

## POPULATION SERVED

In Kansas, 1.4 million working adults would benefit from working and living in a smoke-free environment.

## ESTIMATED COST

There is no evidence of costs being incurred when smoking restrictions are put in place.

### **P2 (7) Improve Healthy Behaviors for Families and Communities: Partnering with Community Organizations**

## POLICY

Expand the volume of community-based wellness programs through partnerships between state agencies and community organizations.

## BACKGROUND

Partnerships are key to developing effective community-based wellness programs. There are many examples of these types of successful partnerships throughout the state. Kansas is in a unique position, in that there are significant foundations within the state with a keen interest in health promotion. This advantage gives Kansas the flexibility to adopt new and inno-

vative strategies to promote health care that are not confined by strict federal funding rules. Kansas can also benefit from the experience of other states. For example, the state of Vermont has developed a successful community engagement strategy aimed at promoting community infrastructure to support healthy lifestyles. Initiatives focus on the built environment (walking trails, bike paths, etc.), physical activity programs in pilot communities, awarding grants to communities for programs that support chronic disease prevention and management, and developing a toolkit for sharing successful evidence-based projects.

Support for additional organizations can improve health outcomes at the local level. For example, the Kansas Association of Counties (KAC) and the Kansas Association of Local Health Departments (KALHD) are seeking to improve birth outcomes by increasing access to early prenatal care through care coordination services and improved outreach efforts. Other examples of local partnerships:

- *Partnerships with Local Health Departments.* In 2004, the state of Kansas awarded grants to 36 local health departments to promote healthy eating practices and tobacco use prevention in addition to promoting physical activity initiatives within their communities. Additional training was later provided on using walking paths as catalysts to promote physical activity and better nutrition. Community grants such as these should be continually promoted across the state to provide needed funding for the construction of fitness centers, biking paths, and other wellness activities.
- *Partnerships with business groups.* In 2004, the state of Kansas and Mid-America Coalition on Healthcare (MACHC) collaborated to implement a pilot worksite wellness project in the Kansas City metropolitan area involving 14 large and medium-sized employers. The 5-year project consists of four phases focusing on blood pressure, cholesterol, physical inactivity, obesity, poor nutrition, and tobacco use. The unique public-private partnership has engaged employers collaboratively with health plans, health care providers, universities, media, pharmaceutical companies, national researchers, and various governmental agencies.



- *Partnerships with other state agencies.* The Kansas Department of Health and Environment partnered with the Kansas Department of Commerce in 2006 to start a worksite Farmer's Market in downtown Topeka to increase access to fresh, locally grown produce to downtown workers. This Farmer's Market has continued into 2007 with greater success. Similarly, the KHPA could partner with Kansas Department of Aging's (KDOA) successful STEPS program to encourage physical activity among seniors, Farmer's Market voucher initiative, and the Life-long Communities program promoting successful aging among seniors.
- *Partnerships with faith communities.* The state of Kansas partners with the Center for Health and Wellness (CHW) to provide community-based hypertension reduction activities in African American churches in Sedgwick County. The program targets undiagnosed cases of hypertension and refers those identified clients for treatment. Monthly blood pressure screenings are conducted in over 35 churches and senior centers. Other faith-based partnerships in Kansas include the United Methodist Healthy Congregation program, providing technical assistance to United Methodist churches to develop a health plan for their congregations.

## STAKEHOLDER INPUT

Advisory Council members commented on a variety of activities in their communities which were improving health behaviors, including the distribution of pedometers and encouragement of walking, public health agencies teaching older adults on how to prepare healthier meals, and chronic disease management program providing bathroom scales to local citizens.

## POPULATION SERVED

The populations served are all residents and visitors to the state of Kansas.

## ESTIMATED COST

The exact costs of a partnership program will be dependent upon the expanse of the program and the scope of work.

### P2 (8) Improve Healthy Behaviors in the Schools: Include Commissioner of Education on KHPA Board

#### POLICY

Expand the KHPA Board to include an ex-officio seat for the Kansas Commissioner of Education.

#### BACKGROUND

The KHPA Board is comprised of nine appointed voting members and six ex-officio members representing government agencies with critical roles in the promotion and development of health care policies, administration of health care programs, and resources throughout Kansas. Inclusion of the education community in fulfilling this mission is essential to establishing a healthy future for our children. From an implementation perspective, the KHPA Board does not have the authority to implement this addition and should make known its intention to the Legislature due to the statutory origin of the KHPA.

#### POPULATION SERVED

Kansas school children will be the greatest beneficiaries of a KHPA Board composition that recognizes the importance of health care policies that include the insight of the education community.

#### ESTIMATED COST

No cost.

### P2 (9) Improve Healthy Behaviors in the Schools: Collect information on Health/Fitness of Kansas School Children

*"I have kids enrolling and being monitored already for cholesterol problems. We know what that means later down the road when they start having heart problems."*

Garden City Provider at Mexican American Ministries



## POLICY

Support the establishment of a state-based surveillance system to monitor trends of overweight, obesity, and fitness status on all public school-aged children in Kansas, as recommended by Governor's Council on Fitness.

## BACKGROUND

Obesity has become the second greatest threat to the long-term health of children, second only to tobacco. The percentage of young people who are overweight has more than tripled since 1980 (Figure 5). As a result, it is projected that one of every three children born in 2000 (and one of every two Hispanic children) will develop diabetes in their lifetime. By 2020, one of every four dollars spent on health care will be used for obesity-related treatments.

Data on childhood obesity in Kansas is currently gathered through surveys. While the current method of self-reporting gives the state a subjective view of the issue, data is lacking on the demographics of the chil-

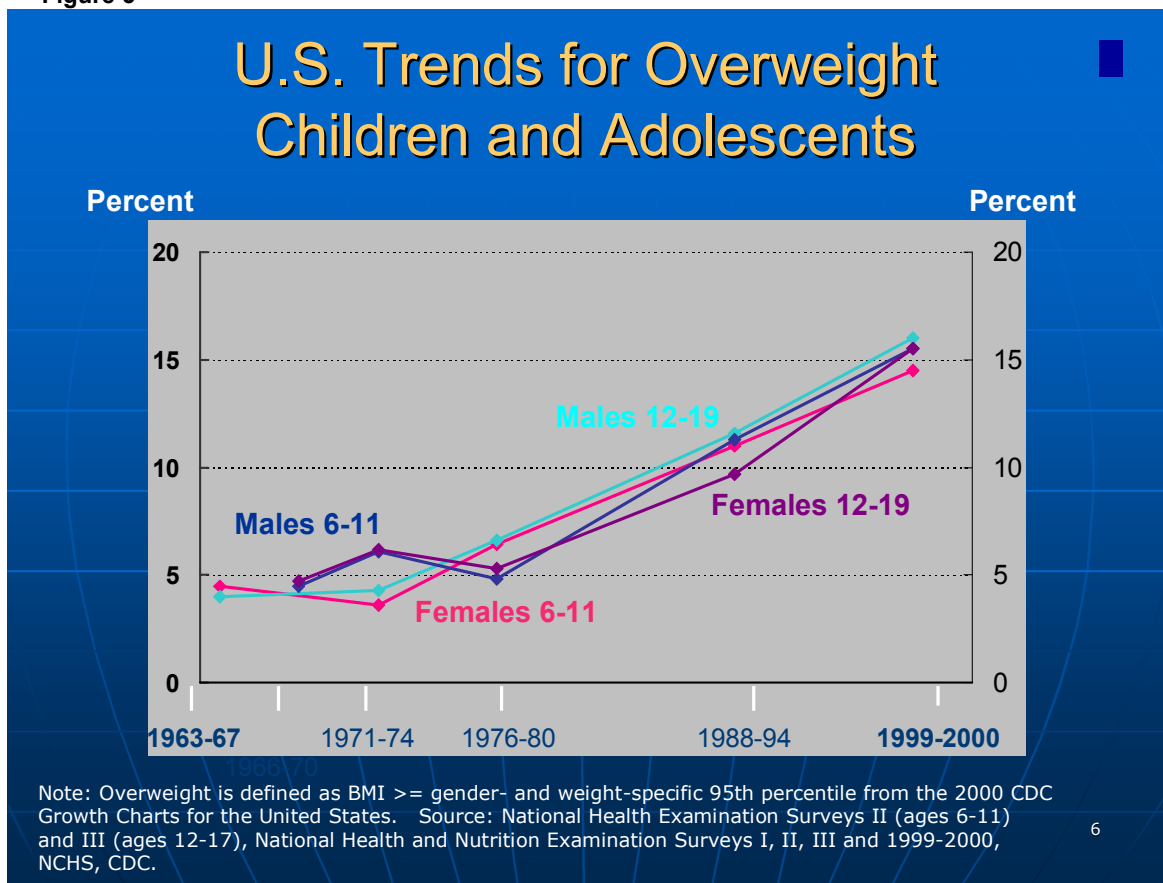
dren most affected. The lack of information means that programs are unable to appropriately target the most vulnerable populations in a cost-effective manner. Schools will need assistance in implementing this policy, as they expressed concern with loss of instructional time to perform the measurements, and with the time and fiscal costs of instituting such a program.

## STAKEHOLDER INPUT

The Governor's Council on Fitness recommends a state-based surveillance system to monitor trends of weight and fitness status on all public school-aged children in Kansas. The Governor's Council on Fitness recommends collection of BMI data and cardio-respiratory fitness data for all public school students in grades pre-K through 12. In addition, a bill introduced during the 2007 legislative session would have originally required BMI and fitness test measurement of Kansas school children (among other provisions).

All the KHPA Advisory Councils supported a number of policies aimed at improving the nutrition and

Figure 5



*"I'm impressed with the new wellness push in schools by getting the pop machines out of the schools. It's a nice push. As a science teacher, I try to push good health habits. We need to show the kids how to better themselves with their habits, showing kids the right ways to eat and to eat healthy meals."*

Congregation Member of the Atchison United Methodist Church

fitness of Kansas children. In addition, more than 80% of public school and school district staff support the collection of BMI, according to a study by the Kansas State Department of Education (KSDE) and the Kansas Health Institute (KHI).

## POPULATION SERVED

For the 2006-2007 school year, there were 465,135 Kansas school children enrolled in grades K-12.

## ESTIMATED COST

The schools would incur some indirect costs for staff training and completion of the BMI data collection and recording.

## P2 (10) Improve Healthy Behaviors in the Schools: Promote Healthy Food Choices in Schools

## POLICY

Adopt policies that encourage Kansas school children to select healthy food choices in school by competitively pricing and marketing these foods and restricting access to foods with little or no nutritional value.

## BACKGROUND

Childhood obesity rates are climbing at an alarming pace. In Kansas, 14% of children aged 10-17 are overweight (Kaiser State Health Facts – Data based on the National Survey of Children's Health). Another 14% are at risk for becoming overweight (Youth Risk

Behavior Surveillance System Data). Measures should be taken to reverse this trend through the adoption of school policies that encourage healthy eating.

Many students have access to vending machines and a la carte menus that facilitate unhealthy food choices. In Kansas, 45% of school food service programs offer a la carte items. Over 90% of public high school students have access to vending machines. Some of the most common purchases are soda, chips, and candy. As greater emphasis is placed on individual responsibility in adopting healthy behaviors, consideration must be given to support children and provide an environment of making healthy food at school a priority.

Policy initiatives in schools are recommended that support implementation of the Kansas School Wellness Policy Model Guidelines for Nutrition (Guidelines). The Guidelines provide recommendations to improve the nutritional quality of all foods and beverages available to students on school premises throughout the school day by addressing competitive pricing and promotion of healthy foods, portion size limitations, restricting access to foods of minimal nutritional value; all of which are effective strategies in reducing amount of soda consumed per week, increasing purchases of fruits, vegetables, and low-fat foods, and reducing overall energy intake.

Because school districts may utilize vending and other competitive food sales revenue to support extracurricular activities in the face of decreased funding from other sources, it is important to change the food options to those that are nutritious. Studies have generally demonstrated positive or neutral fiscal results when contents of school vending machines have been changed to provide more healthy choices.

## STAKEHOLDER INPUT

All the KHPA Advisory Councils supported a number of policies aimed at improving the nutrition and fitness of children. In addition, the Kansas Farm Bureau supports and encourages nutrition education and food handling/preparation training in Kansas schools, monitoring the use of federal funds for nutrition education in order to assure that students and food service personnel receive the benefits of such nutrition training programs, and that health care policy should embody the promotion of personal wellness, fitness, and preventive care. Kansas Acton for Children supports the





creation of health school environments by limiting access to vending machines during the school day.

## **POPULATION SERVED**

For the 2006-2007 school year, there were 465,135 Kansas school children enrolled in grades K-12.

## **ESTIMATED COST**

Depending upon pricing policies, implementation of competitive food restriction programs within Kansas schools may reduce or increase the revenue generated by the sale of those food items.

### **P2 (11) Schools: Physical Fitness and School Health Programs**

## **POLICY**

Strengthen physical education (PE) requirements and expand Coordinated School Health (CSH) programs.

## **BACKGROUND**

The Governor's Council on Fitness has developed a set of recommendations that calls for minimum physical activity and PE requirements that are consistent with the Kansas Wellness Policy Builder developed by the Kansas CSH program. Collaboration is underway between KDHE and the Kansas Department of Education to implement an evidence-based CSH model that provides schools with a framework to address the health and wellness needs of their students and staff.

Some of the recommendations include a minimum of 100-150 minutes of PE per week at the elementary and middle school levels, maintaining the current one unit requirement for high school graduation, and 20 minutes of recess for elementary students daily. Current law mandates PE at the elementary level, but only requires one credit unit total from middle through high school. In addition to requirements of students, the recommendations also emphasize the importance of PE teachers who are specifically trained in the PE field.

Schools are often concerned about taking away instructional time for PE classes, especially in the context of the importance of standardized testing results. However, work is emerging that indicates that improved health and physical activity status of children translates into improvement in standardized test scores. Currently, 11 states mandate physical activity for elementary schools, seven do so for middle/junior high schools, and 10 do so for high schools. Among states that mandate physical activity for elementary schools, only two (Louisiana and New Jersey) meet the national recommendation of 150 minutes or more per week (commonly "daily physical activity").

Policies aimed at increased physical activity in schools have achieved significant attention in recent years. In 2006, legislation was enacted and signed by the Governor on March 10; this Bill supports PE classes for all grades from K-12 and urges the State Board of Education to require some type of scheduled PE class for grades K-12. In 2007, House Bill 2090 (HB 2090) proposed to require the collection of fitness data on students in grades 4, 7, 9, and 12 in order to benchmark the fitness of Kansas students and guide local and state policymakers. The Bill was heard, but did not pass out of the House Education Committee.

## **STAKEHOLDER INPUT**

All the KHPA Advisory Councils supported a number of policies aimed at improving the nutrition and fitness of Kansas children.

## **POPULATION SERVED**

For the 2006-2007 school year, there were 465,135 Kansas school children enrolled in grades K-12.

## **ESTIMATED COST**

The average cost to implement a CSH planning process is \$8,500 per school so the costs to schools would depend upon the number of schools participating in the program. KCSH currently impacts 224 schools, which serve 80,736 students in 39 counties. Funding of \$1.8 million is being requested to implement a statewide comprehensive CSH program for the participation of 100 districts.



**P2 (12) Improve Healthy Behaviors in the Workplace: Develop Grant Program to Facilitate Wellness Initiatives in Small Businesses**

**POLICY**

Develop a community grant program to provide technical assistance and start-up funds to small businesses to assist them in the development of workplace wellness programs.

**BACKGROUND**

Large employers have frequently embraced workplace wellness programs as mechanisms to improve employee health, decrease absenteeism, and enhance productivity. The costs of starting such programs are prohibitive for small employers who often do not have adequate resources and economies of scale to pay for these kinds of programs. The component of “personal responsibility” within health care reform encompasses not only individual choice, but establishing an environment which facilitates the choice for health. Workplace wellness programs embody this strategy.

Well-designed worksite health interventions can have an enormous impact on disease prevention and control, resulting in significant savings in health care spending, improved presenteeism, and increased productivity. A comprehensive worksite wellness program consists of health education, supportive social and physical environments, integration of programs into the organizational structure, linkage to related programs such as employee assistance programs (EAP), and screening programs linking to health care. Comprehensive worksite health promotion programs can yield a \$3 to \$6 return on investment (ROI) for every dollar spent over a 2–5 year period. Worksite health promotion programs can reduce absenteeism, health care, and disability workers’ compensation costs by more than 25% each.

Over 80% of businesses with over 50 employees have some form of health/wellness programs, but they are much less available in small businesses. Small businesses have limited resources and their lack of staff, budget, and wellness knowledge are barriers to providing wellness programs. Once established, however those wellness programs are quite economical costing \$30-\$200 per employee per year.

Data from the US 2000 Census detailing industry employment by size of industry documents the prevalence of small employers in Kansas. Of the 67,900 establishments with employees in Kansas, over 79% are in the under 100 employee size category. Business establishments (28,144) with one to four employees comprise 41.5% of the total, establishments (10,892) with five to nine employees comprise 16% of the total, establishments (6,969) with 10 to 19 employees comprise 10.3% of the total, and businesses (7,833) with 20 to 99 employees comprise 11.5% of the total.

**STAKEHOLDER INPUT**

Members of the Advisory Council supplied information about the success of wellness programs in small businesses. Several provided specific examples of effective strategies utilized at their workplaces.

**POPULATION SERVED**

The population served is employees working for small Kansas firms.

**ESTIMATED COST**

Costs would be \$100,000 SGF for pilot projects to cover costs technical assistance and start-up grants to small businesses.

**P2 (13) Improve Healthy Behaviors in the Workplace: Improve Food Choices in State Cafeterias and Vending Machines**

**POLICY**

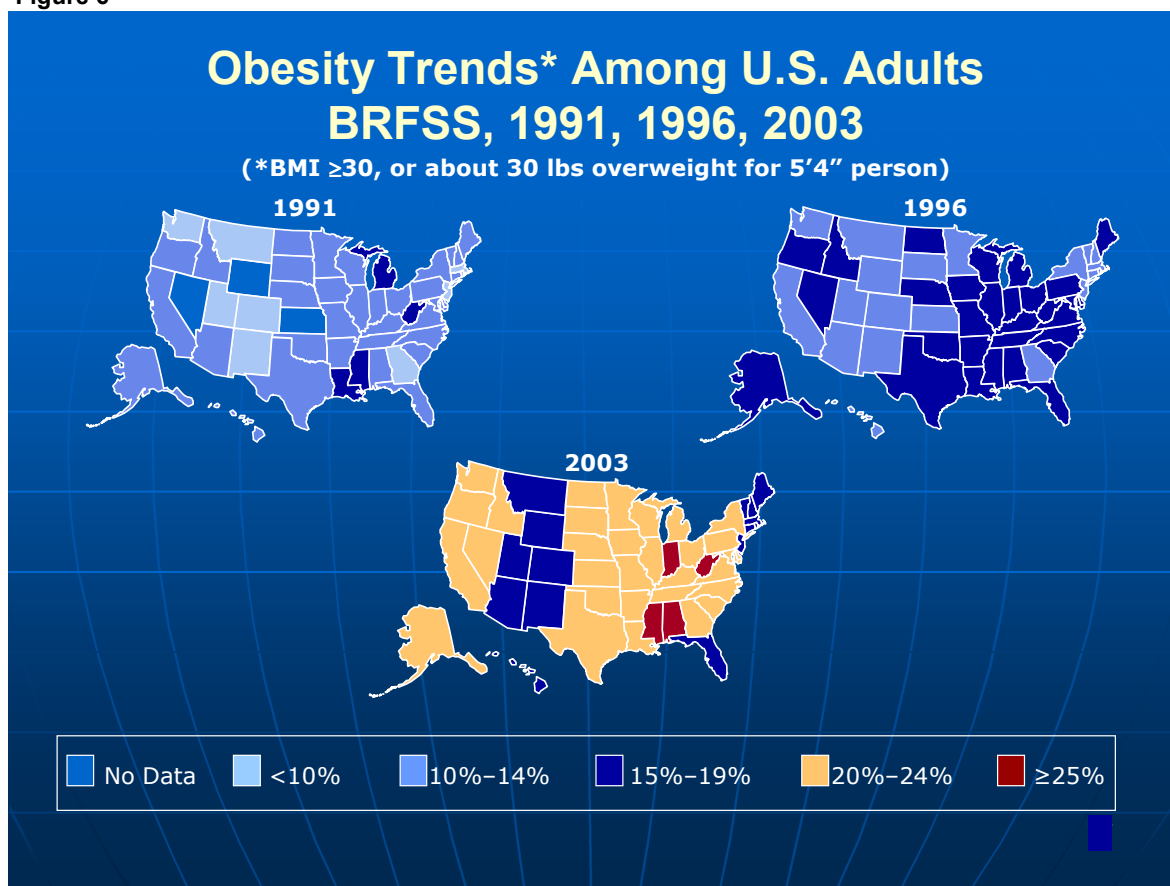
Expand healthy food choices in state agency cafeterias and vending machines. State government has an opportunity to lead by example by providing greater in-house healthy food selections for employees.

**BACKGROUND**

Obesity is a key contributor of many chronic diseases, including some cancers, cardiovascular disease, and diabetes. Both nationally and locally, obesity rates have increased sharply in the past 20 to 30 years (Figure 6). According to the Centers for Disease Control and Prevention (CDC), the obesity rate among



Figure 6



adults aged 20-74 increased from 15% of the population in 1976 to 33% of the population in 2003-2004. The estimated total cost of obesity in the US as of 2000 was approximately \$117 billion.

These statistics are even more sobering in Kansas. In 2006, over 36% of adults were overweight and nearly 26% were obese. Obesity has increased since 2000 when 21% of adult Kansans were obese. Promoting regular physical activity and healthy eating and creating an environment that supports these behaviors are essential to addressing the problem. Research shows that good nutrition can help to lower risk for many chronic diseases, including heart disease, stroke, some cancers, diabetes, and osteoporosis. However, a large gap remains between healthy dietary patterns and what Americans actually eat. In 2005, only one-fourth of US adults ate 5 or more servings of fruits and vegetables each per day. In Kansas as of 2000, 23% of adults consumed 5 servings of fruits and vegetables per day. This proportion has since declined with less than 20% of adult Kansans meeting recommended levels of fruit and vegetable consumption in 2005. Providing more healthy food options in

state cafeterias and vending machines at competitive prices might begin to reverse current trends.

Other states have utilized state government as a starting point for healthy eating options. One program is Arkansas' chronic disease plan in which approximately 10,000 state employees completed the Healthy Employees Lifestyle Program (HELP) pilot. The Arkansas Department of Health provides nutrition related information to its vendors in order to promote stocking vending machines with healthier options. They also have a worksite wellness program "Fit with 5" that encourages workers to get the recommended levels of physical activity of 30 minutes on five or more days of the week and to eat five fruits and vegetables every day.

#### STAKEHOLDER INPUT

Various organizations, such as the Kansas Medical Society, the Kansas Association for Health Underwriters, and the Kansas Farmers Bureau (KFB), have public positions which encourage Kansans to live healthy lifestyles to extend their productive lives and





reduce the demand for expensive health care. The KHPA Advisory Councils also supported improved nutrition and personal responsibility.

## **POPULATION SERVED**

On Oct. 5, 2007 there were 38,130 full-time and 3,416 part-time employees (total of 41,546).

Other populations impacted would include contract workers and employee guests who frequently visit state agency facilities.

## **ESTIMATED COST**

Costs depend on contract negotiation and pricing policies.

### **P2 (14) Additional Prevention Options (1): Inclusion of Dental Coverage for Pregnant Medicaid Beneficiaries**

## **POLICY**

Include coverage of dental health services for pregnant women in the Kansas Medicaid program.

## **BACKGROUND**

Recent studies continue to show that poor oral health has an effect on overall systemic health. One of the most convincing links is between oral infections and poor birth outcomes, specifically low birth weight babies. Providing dental benefits for pregnant women may help reduce this problem.

Kansas Medicaid pays for roughly 40% of births in Kansas. Efforts have been made with Head Start, Women, Infants, and Children (WIC), and in local health programs to educate women on the importance of good oral health during pregnancy, but without dental coverage, pregnant women are without resources to pay for oral health care. Recent evidence based studies have shown a relationship between periodontal disease and premature births and cardiac disease. Avoidance of even one premature birth can save the state from future years of medical services and disability payments.

Currently, Kansas Medicaid coverage only provides emergency dental coverage (mainly tooth extractions) for most adults on Medicaid, including pregnant

women. Providing a complete dental benefit for pregnant women on Medicaid in Kansas will allow them to receive routine cleanings, fillings, and periodontal (gum disease) treatment. This type of treatment will prevent oral health emergencies and oral infections during pregnancy in many women.

Kansas pays the costs of several "million dollar" premature babies a year. The March of Dimes reports that an average premature birth costs as much as \$500,000 over the lifetime of a child. The costs savings of preventing just a few of these births would easily cover the cost of the benefit. Providing additional Medicaid dental funding would support the community health clinics or "dental hubs" as they would receive compensation for treating these previously uninsured patients. The Kansas Legislature has appropriated \$2 million in new money for the state's primary care safety net clinics in FY2008. It includes \$500,000 earmarked for developing access to oral health care through "dental hubs."

Enrollment of dentists in the Kansas Medicaid has improved since the state changed from a capitated managed care plan to fee-for-service. However, when discussing increasing dental benefits for Medicaid beneficiaries, there is concern about the lack of capacity of dental Medicaid providers and low dental reimbursement rates. Oral Health Kansas and the Kansas Dental Association are also preparing cost estimates to increase dental reimbursement rates to help provider enrollment.

## **STAKEHOLDER INPUT**

Oral Health Kansas, the Kansas Dental Association, and the Kansas Association for the Medically Underserved (KAMU) will be asking the Legislature this year for a full adult dental benefit for all Medicaid beneficiaries. In the last two years, the Legislature has expanded funding for disabled adults in waiver programs, but that still leaves approximately 75,500 enrollees without dental coverage. If they are successful in funding a full adult benefit, pregnant women will have dental coverage. Members from the Consumer and Provider Advisory Councils discussed their support for health benefit designs to include dental care coverage, especially for preventive services.

## **POPULATION SERVED**

The population served is pregnant women enrolled in Medicaid.



## ESTIMATED COST

The cost is \$1.3 million AF /\$524,000 SGF for provision of dental benefits to 6,600 pregnant Medicaid enrollees.

### P2 (15) Additional Prevention Options (2): Provide Tobacco Cessation Support for Medicaid Beneficiaries

## POLICY

Improve access to tobacco cessation programs (medications and counseling) in the Kansas Medicaid program in order to reduce tobacco use, improve health outcomes, and decrease health care costs.

## BACKGROUND

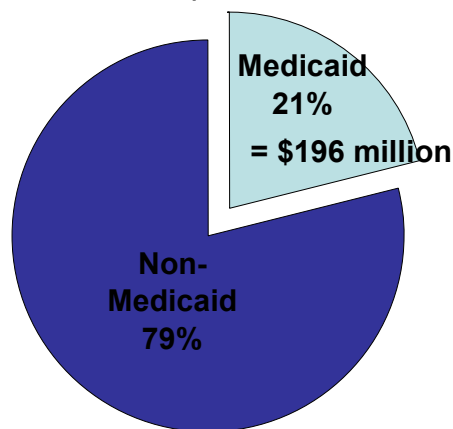
In Kansas, smoking-attributed costs for Medicaid reached \$196 million in 2004 (Figure 7) (CDC Sustaining State Programs for Tobacco Control Data Highlights, 2006) and 49% of Kansas adult smokers attempted to quit and failed in 2004 compared to 55% nationwide. Kansas Medicaid currently covers the medication, Chantix, for up to 24 weeks in a year, but does not cover cessation products, such as inhalers and nasal sprays. Kansas Medicaid also does not cover group, individual, or telephone counseling.

According to the 2004 National Health Interview Survey, approximately 29% of adult Medicaid beneficiaries were current smokers. This figure was higher than the 2005 estimated rate of 20.6% for current smoking among the general population. The smoking

Figure 7

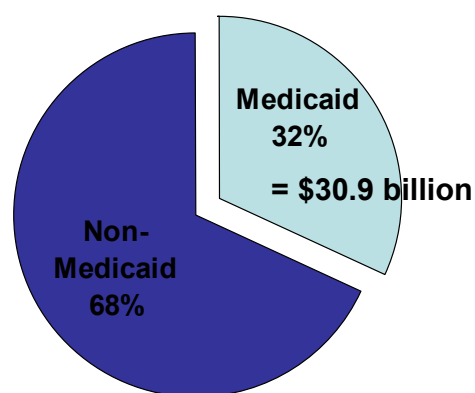
# Direct Health Care Costs Attributable to Tobacco Use

## Annual Health Care Costs of \$927 million



**Kansas**

## Annual Health Care Costs of \$96.7 billion



**U.S.**

Source: CDC, *Sustaining State Programs for Tobacco Control: Data Highlights 2006* [and underlying CDC data and estimates], [http://www.cdc.gov/tobacco/data\\_statistics/state\\_data/data\\_highlights/2006/index.htm](http://www.cdc.gov/tobacco/data_statistics/state_data/data_highlights/2006/index.htm)



rate for adults in Kansas is approximately 17.8%, and national data suggests the rate for Kansas Medicaid beneficiaries is higher than that of the general state population. (<http://www.statehealthfacts.org>).

In order to decrease smoking rates, the 2000 Public Health Service Clinical Practice Guidelines recommended tobacco-dependence treatment, which included medication and counseling. One of the 2010 national health objectives is to increase insurance coverage of evidence-based treatments for tobacco dependence among all 51 Medicaid programs. Kansas Medicaid currently provides reimbursement for some pharmaceuticals products to treat smoking cessation; however, the state does not reimburse for smoking cessation counseling. This proposal would expand reimbursement for smoking cessation treatment to include counseling in an individual and/or group setting. The expansion would be consistent with the changes occurring within the SEHP which will include coverage of pharmaceuticals, as well as specific smoking cessation programs.

### STAKEHOLDER INPUT

Consumer Advisory Council believes health benefit designs should reflect life-style behaviors to incentivize and reward health; the Provider Advisory Council recognizes that changes to be included in health benefit designs to incentivize and reward health need to address both the current health care delivery system and individual behaviors; and the Purchaser Advisory Council believes all sectors of government should be involved in adoption of public policies to decrease tobacco use because health plans and insurers are not the only answer.

### POPULATION SERVED

The approximate 83,200 Kansas Medicaid beneficiaries who smoke would benefit from the increased coverage of tobacco cessation, improving health and lowering health care costs. The Kansas population overall would benefit from a less prevalent smoking environment.

### ESTIMATED COST

To provide coverage for a counseling session for tobacco cessation would cost ( AF) approximately \$500,000 annually.

The Medicare rate for a 10-minute counseling session as part of physician office visit and referral is \$11.61. During FY2007, 10,778 beneficiaries received \$2.1 million worth of tobacco cessation pharmaceuticals. The CDC (1999) reported that 10.0% of smokers aged 18 years and older use the full amount of available cessation services to quit smoking. We assume that the current beneficiaries receiving Medicaid-funded drugs would take advantage of the additional counseling services and an additional 32,000 beneficiaries, or half of all Medicaid smokers, would seek treatment to stop smoking.

## P2. (16) Additional Prevention Options (3): Improve Access to Cancer Screening

### POLICY

Increased screenings for breast, cervical, prostate, and colon cancer through expansion of the Early Detection Works (EDW) program.

### BACKGROUND

One of the most significant ways of improving health and decreasing health care costs is to remove barriers to preventive care. Screenings are an effective way to identify those at risk of future disease, or to unmask the disease itself while still in the earliest stages of development. Disease caught early leads to improved efficacy of treatment and decreased long-term morbidity, mortality, and health care costs.

The expense of cancer screening is often raised as a concern. While short-term costs for screening

*"When it comes to chronic illness and prevention, you have to have a plan before it [your body] can fail. You have to change your attitudes about the way you're approaching things. A lot of what I'm hearing is serving the people once they are sick. The focus needs to come back to prevention and helping them before they are sick."*

Consumer at Center for Health & Wellness in Wichita



and treatment may rise to a small degree, the long-term savings resulting from treating cancer in its early stages as opposed to costly treatment that accompanies advanced cases will provide for greater cost savings overall. The cost of these screening recommendations pertains only to data addressing need in FY2009. Changes in health care programs, including potential expansions of Medicaid and Premium Assistance programs, may alter funding needs and eligibility levels in future budget cycles.

- **Breast and Cervical Cancer.** Studies show that breast and cervical cancers that result disproportionately in death among women who are uninsured or underinsured could be significantly reduced by increasing screening rates among at-risk women. Timely mammography screening among women 40 or older may prevent 15% to 30% of all deaths from breast cancer. In Kansas, nearly 400 women die of breast cancer every year, yet access to timely screening could prevent between 60 and 120 of those deaths. If detected early, the survival rate is 90%. The survival rate plummets to 20% when detection is late. Similarly, cervical cytology or pap smears results in detection and treatment of precancerous lesions and cervical cancer at an early stage. In the last five years, an average of 35 women have died annually. Approximately 50% of those deaths would be prevented with adequate screening.

The EDW program is funded by a cooperative agreement between the CDC and KDHE. The program helps low-income, uninsured, and underserved women between the ages of 40 and 64 gain access to lifesaving, early detection screening services for breast and cervical cancers. The EDW program served 7,200 women in FY2006 and an estimated 6,200 Kansas women in FY2007. These results are encouraging but the need is significant. Over 27,000 women may qualify for EDW services in Kansas.

- **Prostate Cancer.** Prostate cancer is the most common cancer diagnosed in men. More than 1,800 cases are annually diagnosed in Kansas, and 250 men die from prostate cancer each year. Screening for patients at high risk of pros-

tate cancer based on race, age, lifestyle, and family history will result in greatly increased survival rates. While prostate cancer occurs more frequently at age 50, screening should begin at age 40 for those who are at high risk. Based on income, lack of insurance and age, it is estimated that 21,000 men would qualify for prostate cancer screening.

- **Colorectal Cancer:** Colorectal cancer usually develops from precancerous polyps in the colon or rectum. Screening tests detect precancerous polyps so that they can be removed before becoming cancerous. Screening can also detect colorectal cancer early, when treatment is most effective. Screening should occur for all persons over age 50. In Kansas, an average of 550 persons died each year of colorectal cancer. The CDC indicates that routine screening for colorectal cancer can reduce this number by at least 60%.

## POPULATION SERVED

All three programs are targeted to those at high clinical risk but lacking the income and insurance resources to access screenings. Expansion of the EDW program at the cost indicated below may allow a total of approximately 7,500 women to be served, which is an increase of 1,700 over the current service population. Funding of a prostate cancer screening program is estimated to serve just over 6,100 men at risk. The colorectal cancer screening effort may provide care for over 12,000 Kansans.

## ESTIMATED COST

The total cost estimate of the combined programs is \$6.7 million for FY2009 and is estimated as follows:

- Breast and Cervical Cancer Screening and Diagnostics = \$1,389,545
- Prostate Cancer Screening and Diagnostics = \$1,287,621
- Colorectal Cancer Screening and Diagnostic = \$3,989,773



## PROVIDING AND PROTECTING AFFORDABLE HEALTH INSURANCE (P3)

### BACKGROUND

One of the three KHPA goals for health reform in Kansas is providing and protecting affordable health insurance. Underlying this goal is the need for all Kansans to have access to affordable health insurance in order to reduce barriers to receiving appropriate, adequate, and timely health care services.

### BACKGROUND ON HEALTH INSURANCE IN THE UNITED STATES<sup>10</sup>

Employers, both private and public, are the primary source of health insurance for people under age 65 (Medicare covers most of the elderly). Some 160 million US workers and their dependents receive health benefits through the workplace. But in recent years, good, comprehensive coverage has been harder to come by. Although annual growth in national health care expenditures and premiums has leveled off at around 7%, it continues to outpace economic and wage growth by a wide margin. High and unstable rates among the smallest businesses discourage own-

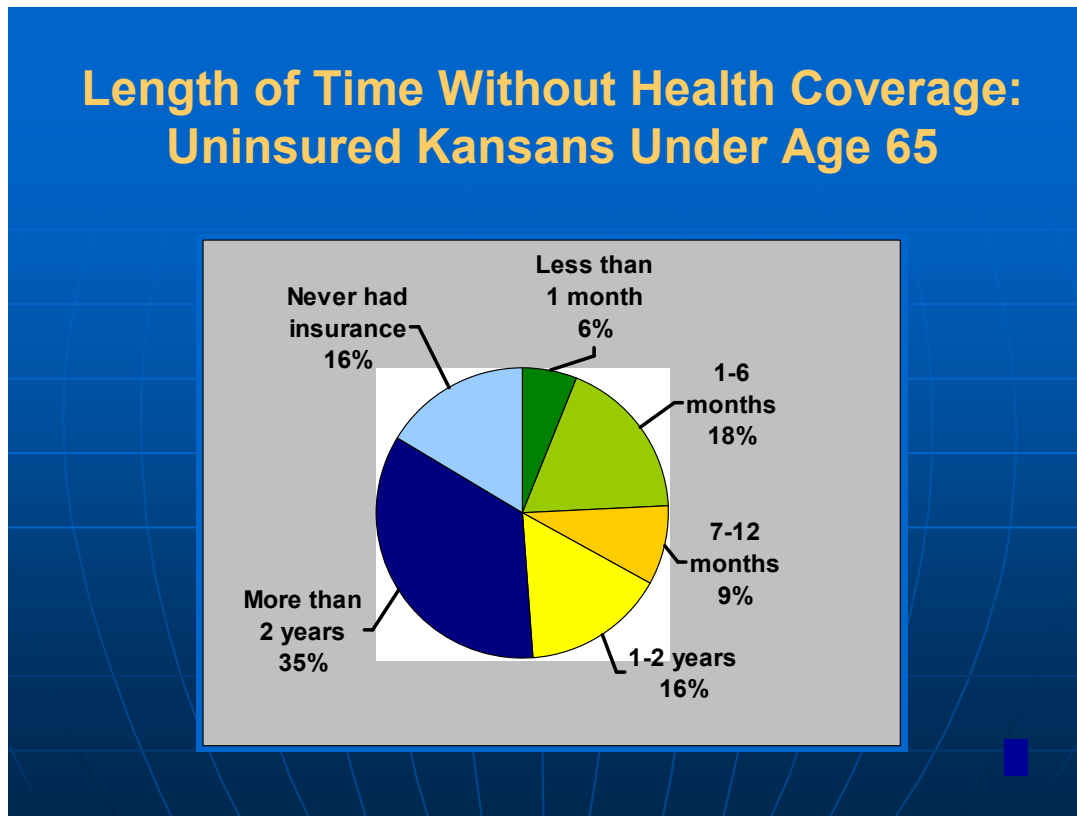
ers who would like to begin offering coverage. Employers who provide health benefits—especially small firms—are finding it difficult to maintain benefits at current levels. Businesses have tried to cope by sharing more of their expenses with employees, but some small companies have eliminated health benefits altogether. With increasing premiums and tighter benefits, employees find it more and more difficult to afford to take up employer-sponsored coverage.

### BACKGROUND ON HEALTH INSURANCE IN KANSAS<sup>11, 12, 13</sup>

In Kansas, approximately 11% of the population, or nearly 300,000 people, are uninsured. Although some uninsured Kansans have been without health insurance for a short period of time, the majority are chronically uninsured. Sixty-seven percent Kansans have been uninsured for over one year with 16% never having insurance (Figure 8).

Misconceptions about the uninsured are very common; for example, some believe that individuals

Figure 8



*"I put off gallbladder surgery for 15 years until I had a job that offered health insurance. I was forced to live in pain for a long time."*

Patient at Silver City Health Clinic  
in Kansas City (Safety Net Clinic)

who lack health insurance are unemployed. On the contrary, 95% of uninsured Kansans live in a household with at least one worker. Individuals most at-risk for lacking health insurance include young adults, individuals employed by small businesses, racial and ethnic minorities, and low-income individuals. Lack of recommended preventive care is associated with both income and health insurance status.

Compared to other groups, young adults ages 18-34 have higher uninsured rates. Just under 20% of individuals ages 19-24 are uninsured compared to 10% of Kansans ages 35-64.

Among racial and ethnic minorities Hispanics are more frequently lacking health insurance. Nearly 30%

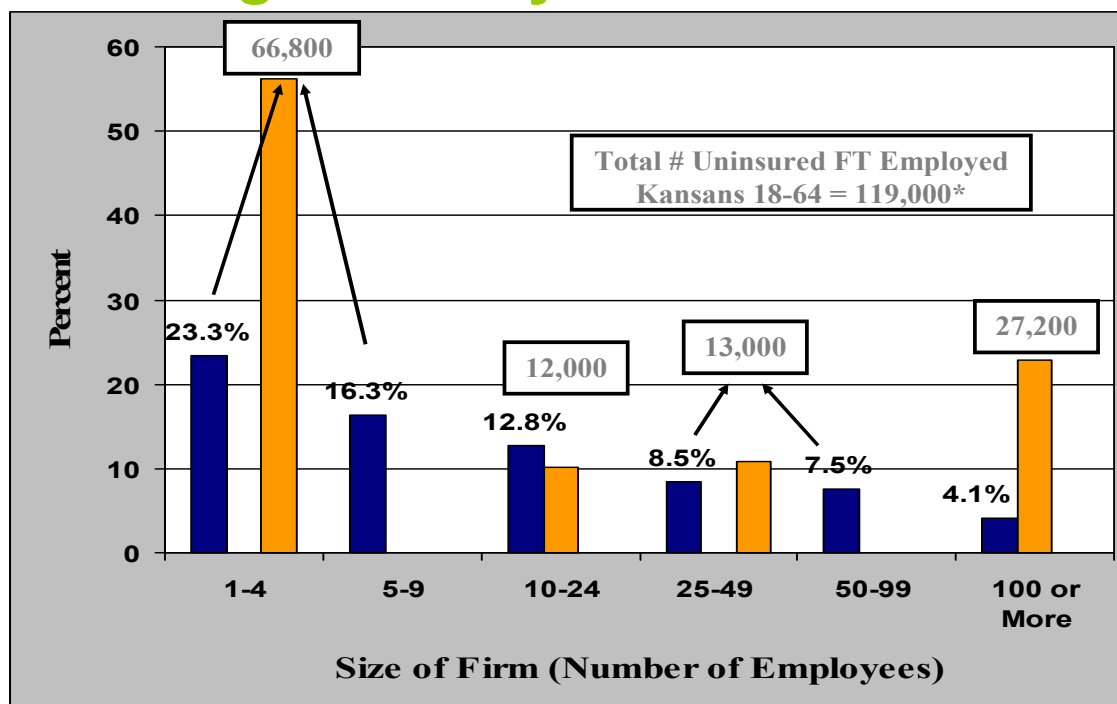
of Hispanics versus 9% of non-Hispanic whites in Kansas were uninsured for 2004-2005. In addition, non-Hispanic Blacks are 1.5 times more likely to be uninsured than non-Hispanic Whites with almost 15% uninsured during that same time period.

Income level is another predictor for being uninsured. Low-income individuals are more likely to be uninsured than higher income individuals. For individuals with annual family incomes of less than \$25,000, 22% were uninsured with another 13% uninsured for those with family incomes between \$25,000 and \$50,000.

Kansas faces challenges in terms of health insurance availability and affordability, particularly for small employers. Employees of small businesses are disproportionately represented among the uninsured. Almost half of the uninsured full-time working adults in Kansas are employed by firms with less than 50 employees (Figure 9). Many small business employers are unable to, or choose not to, offer health insurance as an employee benefit because of the cost, complexity, and unknown risk of administering health insurance.

Figure 9

## Uninsured Full-Time Employed Kansans Age 18-64 by Size of Firm





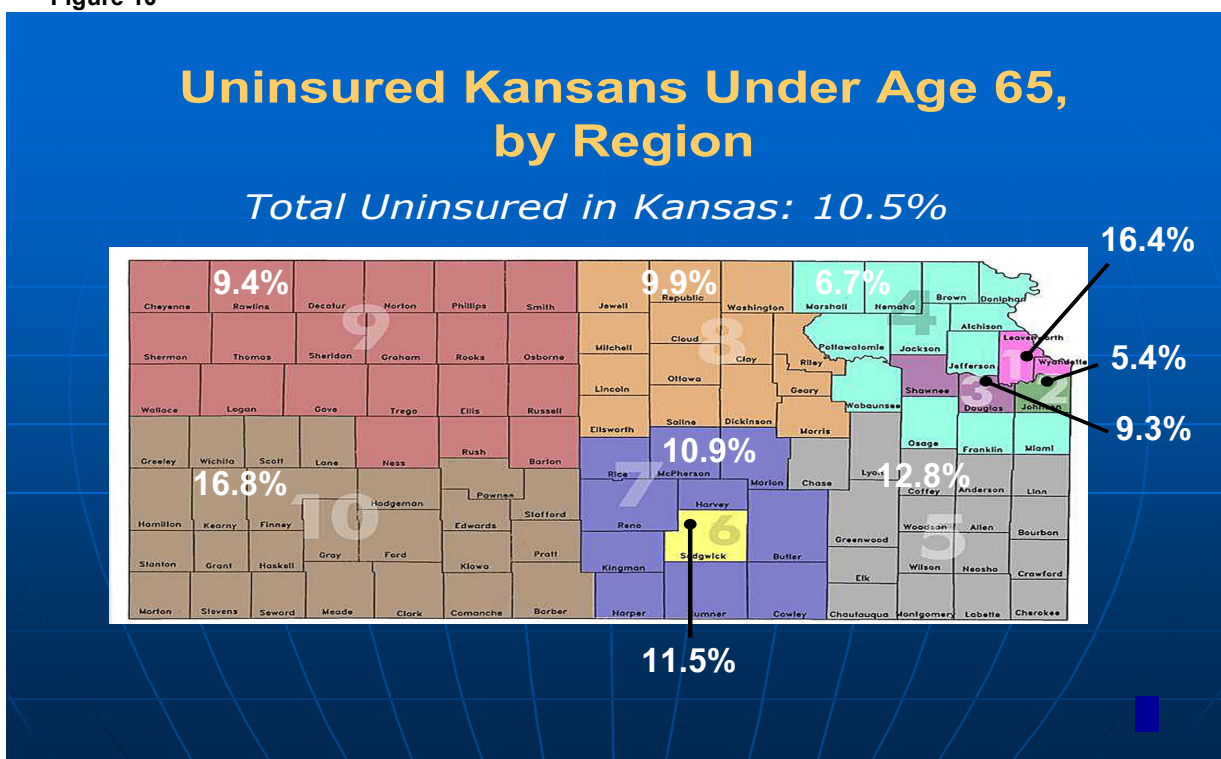
Geographical location is also a determinant of health insurance status; nearly 17% of Kansans living in the southwest are uninsured (Figure 10). Of the eight counties in Kansas with uninsurance rates at or above 18%, six of them are located in southwest Kansas. One explanation is due to this region having the largest proportion of Hispanics, whom as discussed above, have the highest percentage of its population uninsured.

For more than a decade the number of uninsured Kansans has remained static hovering around 11%, and past insurance reforms have had minimal impact on improving access to health insurance in Kansas. The state has undertaken a number of incremental policy actions to improve access to health insurance for other sub-populations of Kansans. Health insurance policies enacted in Kansas aimed at improving small employer access to health insurance include guaranteed access by small employers to all insurance plans offered by carriers and the establishment of premium rating bands. To address access problems of those in the individual market who are denied health insurance due to existing health problems, the legislature established a "high-risk" pool, but a limited number of persons have used this mechanism due to

the high premium costs. Individuals and small groups remain subject to significant variation in insurance premiums, leaving rates unaffordable for some and discouraging others from entering the market for fear that future rate increases will drive them back out.

Increasingly, Kansans in various venues are expressing concern about their continued access to affordable health insurance. A September 2003 poll of Kansas residents' views of the health care system commissioned by the KHI and conducted by Harvard School of Public Health, found that 78% of Kansans felt that funding programs that help small businesses find affordable health insurance was an extremely or very important priority for the state's health care agenda. And when asked if cost, quality, or access was the most important health care issue at the present time, 38% of Kansans felt that access to health care was the most important, compared to 48% for cost, and 9% for quality<sup>14</sup>. A 2004 survey of small business' health insurance experience revealed increasing vulnerability in continued provision of health insurance to employees. Kansas employers participating in the 2004 Small Business Health Insurance Survey reported that insurance premiums had increased substantially from 2003 to 2004 with over 30% of firms

Figure 10



reporting that their premiums rose by 16-25% and 28% reporting that their premiums rose over 25%. More than one-fifth of the firms reported that they were considering dropping coverage, and nearly three-fifths were planning to increase employee contributions.

## POLICY OPTION—UPDATED SEQUENTIAL PLAN\*

The KHPA Board considered a broad range of various health insurance models to increase access to health care in Kansas. After careful consideration of the financing, administrative, and political challenges, the Board is recommending the “Updated Sequential Model” as a meaningful expansion of health insurance focusing first on those most in need. The three initiatives of the Updated Sequential plan (Figure 11) are designed to provide and protect affordable health insurance for Kansans are:

- **Access to Care for Kansas Children and Young Adults:** For children, target and enroll those currently eligible but not enrolled in Medicaid and HealthWave. For young adults, change Kansas insurance law to allow parents to keep young adults (through age 25 years) on their family insurance plan and de-

velop Young Adult Plans (YAPs) for health care coverage with limited benefit packages and lower premiums. The reforms will have targets that trigger additional review by the KHPA Board if not met.

- **Expanding Insurance for Low-Income Kansans:** Expand the Premium Assistance program to include adults (without children) earning up to 100% FPL (\$10,210 annually).
- **Affordable Coverage for Small Business:** Help small employers better access health insurance, developing a voluntary health insurance clearinghouse to assist small employers access health insurance and tax-preferred health insurance premiums through Section 125 plans. Stabilize and lower health insurance rates for the smallest and newest businesses by creating a new micro-market for sole proprietors and very small employers (one to ten employees) within the small group market.

## IMPLEMENTATION CONSIDERATIONS

From a practical perspective, the proposed Reforms:

Figure 11

## Updated Sequential Reform Plan \*

Summary of Health Insurance Reform	
<ul style="list-style-type: none"> <li>Multi-Part Reform – Targeted Insurance Market Reform for 3 Key Populations: Children and Young Adults, Low Income Kansans, and Small Businesses</li> </ul>	
STRUCTURE	POLICY DECISIONS
<ol style="list-style-type: none"> <li>Children and Young Adults - Targeted Outreach <ul style="list-style-type: none"> <li>Children: Create Targeted outreach and web-based enrollment for Medicaid/SCHIP eligible but not enrolled children</li> <li>Young Adult: Allow young adults up to age 25 to stay in family insurance plan and develop affordable Young Adult Plans (YAPs) for adults 19-24 years old</li> </ul> </li> <li>Low Income Kansans - Premium Assistance SB 11 for Childless Adults <ul style="list-style-type: none"> <li>Expand up to 100% FPL</li> </ul> </li> <li>Small Businesses - Voluntary Insurance Clearinghouse with Targeted Market Reform <ul style="list-style-type: none"> <li>Create new Very Small Group (VSG: Sole proprietors plus 1-10 ee's) and provide subsidized reinsurance to new VSG market</li> <li>Assist Small Groups (1-50) in Section 125</li> <li>Other Pilot Projects to Improve Access to Insurance for Small Businesses</li> </ul> </li> </ol>	<ol style="list-style-type: none"> <li>Program Design – Market Driven Reform: <ul style="list-style-type: none"> <li>Children: Develop programs for Targeted Outreach &amp; Coordinate with Web-based Enrollment</li> <li>Young Adults: Change Kansas Insurance Laws</li> <li>Low Income Kansans : Funding and Vehicle to Expand Premium Assistance SB11 to 100% for Childless Adults</li> <li>VSG: Develop Program and Determine Funding for Reinsurance Program</li> <li>Choose Vehicle(s) for Educating all Small Employers about Section 125</li> </ul> </li> </ol>
ISSUES	
<ul style="list-style-type: none"> <li>Cost of Additional Outreach</li> <li>Combined Market – Selection v. Level-Playing Field</li> <li>State Match/Vehicle</li> </ul>	





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More detail on these components of the Updated Sequential reform plan and other reform options are available in a separate document through the United Methodist Health Ministry Fund ([www.healthfund.org](http://www.healthfund.org)).

- Are Voluntary and Targeted – The feedback from the Listening Tour, the Steering Committee, the Advisory Councils, and public comment was that Kansas was not ready for mandatory health insurance, but instead needs reforms targeted at populations that have struggled accessing affordable health insurance. The Updated Sequential option delivers targeted assistance.
- Have a Positive Impact Now – The individual initiatives with the Updated Sequential plan represent a strong first step on the road to reform, covering a third of Kansans previously uninsured.
- Have Relatively Few Implementation Barriers/Issues – Without attempting to minimize the barriers or issues, the Updated Sequential plan has relatively fewer issues than other reforms originally considered but ultimately dismissed. Given this, challenges that remain include:
  - ◆ Funding for additional \$71 million in state funds required;
  - ◆ Federal approval for changes;
  - ◆ State approval for changes; and
  - ◆ Administrative costs have yet to be determined.

### **P3 (1) Providing and Protecting Affordable Health Insurance: Access to Care for Kansas Children and Young Adults**

#### **POLICY**

For children, target and enroll the children up to 200% FPL currently eligible but not enrolled in Health-Wave 19 and 21. For young adults, change Kansas insurance law to allow parents to keep young adults (through age 25 years) on their family insurance plan and develop specific Young Adult Plans (YAPs) that provide health care insurance options with limited benefit packages and lower premiums. (Note: In the United Methodist Health Ministry Fund report, YAPs are discussed within the third initiative describing voluntary insurance market reforms.)

The policy would include specific targets and timelines for the improved enrollment for children and young adults, that if not met, would trigger additional review by the KHPA Board. This trigger mechanism will initiate the KHPA Board's review of further policy options, including the consideration of mandating health insurance coverage for children in Kansas.

#### **BACKGROUND**

States that have been successful at increasing enrollment penetration for eligible but not enrolled in government-funded health care have extended their outreach programs operationally and included web-based enrollment, public-program coordination/collaboration, school-based outreach programs, and out-stationing eligibility workers with culturally competent community partners. Each of these efforts entails moving the point of engagement with the child or family into the family's everyday life through a known contact, local geography or both.

Just as with the broader uninsured population, there are many reasons young adults lack health care coverage, but key differences of the young adult population can be capitalized upon. First, young adults are more likely than their uninsured older counterparts to live at home, be supported by their parents, or be enrolled in secondary education institutions. Secondly, young adults typically enter the workforce in lower paying jobs and are more likely to work in jobs where health insurance is not offered. Third, young adults



are, in general, healthier than their older counterparts and may see less benefit in paying top dollar for comprehensive health insurance plans. A change in Kansas insurance law to allow parents to keep young adults on their family insurance plan through age 25 would assist in providing transitional insurance to young adults as they leave home, enter the workforce, and gain employer-sponsored coverage. Development of YAPs – health insurance products specifically designed for adults aged 19-24 years old – would be a voluntary program aimed at offering a market specific insurance product with a limited benefit package and correspondingly lower premiums. These plans would be developed by the state in conjunction with private health insurers. This again would require changes to Kansas insurance law. Kansas would need to develop regulations covering areas such as who could sell the product, minimum coverage standards, and rating requirements for the product.

## STAKEHOLDER INPUT

Stakeholder input and KHPA Board deliberations focused on increasing access to health services by maximizing the use of existing health insurance coverage. The KHPA Board voiced strong support for policies to insure all children in Kansas have access to health insurance. Aggressive outreach and web-based enrollment is seen as a first step in ensuring access. The KHPA Board focused on developing strategies for children and young adults encouraging them to enroll in existing insurance currently available to them. Another important consideration discussed by the Board was to begin to develop a culture of valuing insurance early on in all Kansans. The Board felt it important to have children and young adults experience the value of health insurance starting an early age.

## POPULATION SERVED

15,000 additional children would enroll in Medicaid and approximately 5,000 additional children would enroll in SCHIP as a result of an extremely visible and effective outreach, web-based enrollment and facilitated enrollment processes specifically targeting uninsured lower income children eligible for public programs.

Developing Young Adult Plans (YAPs) with limited benefits targeted at young adults ages 19-24 years old would insure 15,000 additional young adults.

## COST ESTIMATE

Children and Young Adults

- \$22 million AF
- \$14 million SGF

## FINANCING CONSIDERATIONS

For the child-focused targeted outreach and web-based enrollment, effective new enrollment rates are projected to be high compared to the typical range of take-up rates assumed for public programs. Also, to employ these innovative strategies, the outreach costs per additional enrollee for these currently eligible but not enrolled children will be greater in comparison to Kansas' historical outreach costs per additional enrollee.

For the creation of affordable YAPs, the challenge for Kansas health policy-makers is to develop the regulations so that they balance affordability with comprehensive coverage.

## P3 (2) Providing and Protecting Affordable Health Insurance: Expanding Insurance for Low-Income Kansans

## POLICY

Expand population for the Premium Assistance program to include adults (without children) earning up to 100% FPL (\$10,210 annually).

## BACKGROUND

This voluntary program is aimed at integrating the poorest childless adults into the health care system by providing them with subsidized access to health care insurance. Adults without children do not fit within Medicaid's traditional eligibility categories, although the Centers for Medicare & Medicaid Services (CMS) has provided states with additional options within the Deficit Reduction Act (DRA). States have taken a variety of approaches to covering childless adults, typically either through state-



only programs like Connecticut's State Administered General Assistance (SAGA) program or by pursuing waiver authority through the federal government and the CMS waiver process.

The structure for this initiative would be an expansion of the covered population eligible for Premium Assistance as specified in SB 11. The newly eligible individuals could be served within the same administrative structure that is being developed for the current SB 11 Premium Assistance program.

### STAKEHOLDER INPUT

Stakeholder input focused on leveling the playing field to assist low income Kansans' to getting access to health insurance.

### POPULATION SERVED

The population served are adults (without children) earning up to 100% FPL (\$10,210 annually). 39,000 low income Kansans would become insured.

### COST ESTIMATE

Low Income Kansans

- \$119 Million AF
- \$56 Million SGF

### FINANCING CONSIDERATIONS

The model allowed for joint financing between the state and federal governments, however stand-alone State financing is also an option.

If the Governor and the Kansas Legislature made the policy decision to implement a state-only program, Kansas could implement a state-only program fairly quickly by building upon the existing Kansas public program infrastructure. However, if the policy decision is to pursue federal matching funds for childless adults, significant challenges may exist depending upon whether the State could pursue approval using flexibility through the Deficit Reduction Act (DRA) or whether the State would be required to pursue a waiver. If required to pursue a waiver, Kansas would need to determine the appropriate waiver vehicle to use. Regardless of the waiver vehicle and strategy selected, the second and perhaps the more vexing challenge would be meeting budget neutrality.

If Kansas chose to pursue a state-only program for childless adults, the price tag would be \$140 million

for a fully implemented program (at the current take-up rates). Alternatively, to achieve CMS budget neutrality for a federal program waiver, the state would need to find reductions in federal spending on the order of approximately \$63 million annually (once the childless adults hit full enrollment).

### P3 (3) Providing and Protecting Affordable Health Insurance: Affordable Coverage for Small Business

### POLICY

Help small employers better access health insurance by developing a voluntary health insurance clearinghouse to assist small employers to access health insurance and tax-preferred health insurance premiums through Section 125 plans. Stabilize and lower health insurance rates for the smallest and newest businesses by creating a new "micro-market" for sole proprietors and very small employers (VSG - one to ten employees) within the small group market. Establish a reinsurance program to spread the risk of this new micro-market among all carriers and the State.

### STAKEHOLDER INPUT

The KHPA Board received a tremendous amount of input describing the need to make coverage more accessible and affordable for small businesses. The input directed the KHPA Board to consider ways to further segment the small employer population into smaller sub-populations and to consider a Kansas-specific adaptation of a health insurance connector/exchange. The Board described this as a voluntary insurance clearinghouse to provide administrative functions to the small employer market.

### POPULATION SERVED

Overall, the new VSG market would insure 5,900 working Kansans and their families prior to the impact of the reinsurance program. The introduction of the reinsurance program and the subsequent drop in premium would result in an additional 6,000 working Kansans and their families insured.



*"We have 62 employees. We can't find affordable health insurance. We watch real carefully legislation that is out there to help small businesses. Some kind of help or incentives would be helpful for insurance so that we can give our employees coverage."*

Wellington Small Business Owner

The newly established voluntary insurance clearinghouse will be available to assist all of Kansas' small employer groups but has no direct population impact.

### **COST ESTIMATE**

Small Businesses

- -\$5 Million AF\*
- \$1 Million SGF

(\*Note: At the person level, the uncompensated care costs for the previously uninsured are reduced due to this change, hence the reduction in All Funds shown above.. Practically, however, at the program level, the State of Kansas will not change the state's Disproportionate Share Hospital reimbursement methodology.)

### **MARKETPLACE CONSIDERATIONS**

During the numerous discussions with the KHPA Board surrounding potential insurance market reforms, the concept of "Do No Harm" was introduced. In the context of health insurance market reform, "Do No Harm" conveyed the KHPA Board's desire to ensure that the market reforms being considered would only improve the workings of the admittedly complex health insurance market. To ensure the reforms "Do No Harm," substantial review of Kansas insurance law will need to take place to ensure a level-playing field exists in the context of the new markets proposed here for VSGs and YAPs. Due to the complex and inter-related nature of the health insurance market, equally as importantly is the need to consider the proposed reforms in the context of the larger health insurance market in Kansas.

## **SUMMARY OF THE UPDATED SEQUENTIAL PLAN**

The individual components of the Updated Sequential Model, as fully implemented, each decrease the number of Kansans without health care insurance. Modeling results indicate the total effect of the Updated Sequential plan would be a 30% decrease in the number of uninsured Kansans (non-elderly).

### **POPULATION SERVED**

The number of uninsured Kansans would drop by 86,000 , from 260,000 to 174,000 (Figure 12).

- Children and Young Adults
  - ♦ 20,000 more children would be insured through public program outreach.
  - ♦ 15,000 more young adults would insured due to new products being offered at the Insurance Clearinghouse.
- Low Income Kansans
  - ♦ 39,000 more childless adults with incomes below 100% FPL would be insured through an expansion of the Premium Assistance SB 11 Program.
- Small Businesses
  - ♦ 12,000 more very small groups (sole proprietors and 1 to 10 employees) would be insured through the market combination and reinsurance efforts.
  - ♦ Section 125 assistance would encourage small businesses to offer tax-preferred health insurance premiums.

After full implementation of the Updated Sequential option, Kansas will have one of the lowest uninsured rates in the country with only 7% of Kansans lacking health care coverage.

### **COST ESTIMATE**

While the individual components of the Updated Sequential Model, as fully implemented, each decrease the number of Kansans without health care insurance, the impact upon All Funds and State Gen



eral Funds varies substantially (Figures 13 and 14).

- Children and Young Adults
  - ◆ \$22 Million AF
  - ◆ \$14 Million SGF
- Low Income Kansans
  - ◆ \$119 Million AF
  - ◆ \$56 Million SGF
- Small Businesses
  - ◆ -\$5 Million AF\*
  - ◆ \$1 Million SGF

(\*Note: At the person level, the uncompensated care costs for the previously uninsured are reduced due to this change, hence the reduction in All Funds shown above.. Practically, however, at the program level, the State of Kansas will not change the State's Disproportionate Share Hospital reimbursement methodology.)

The net cost of the Updated Sequential plan is an increase in expenditures (AF) for non-elderly Kansans of \$136 million. After full-implementation of all three initiatives that make up the Updated Sequential plan, State General Fund expenditures would increase by \$71 million.

**Figure 12. Changes in Population under Updated Sequential Plan**

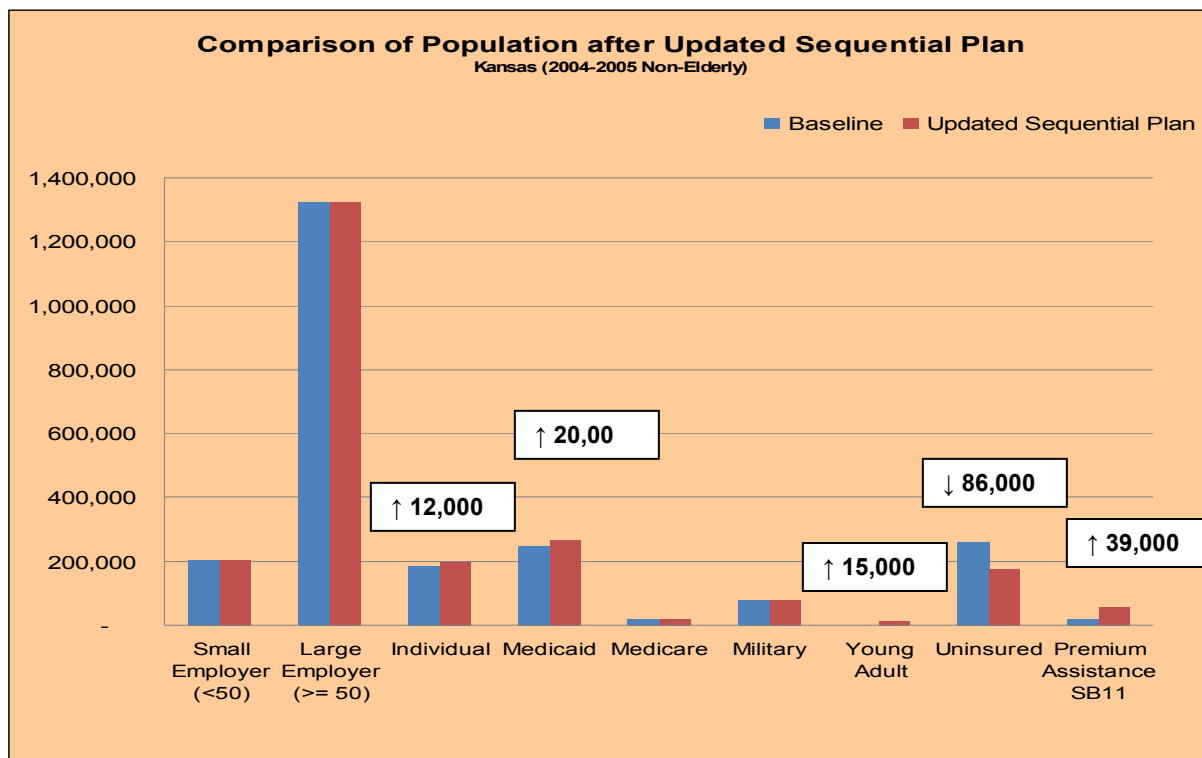
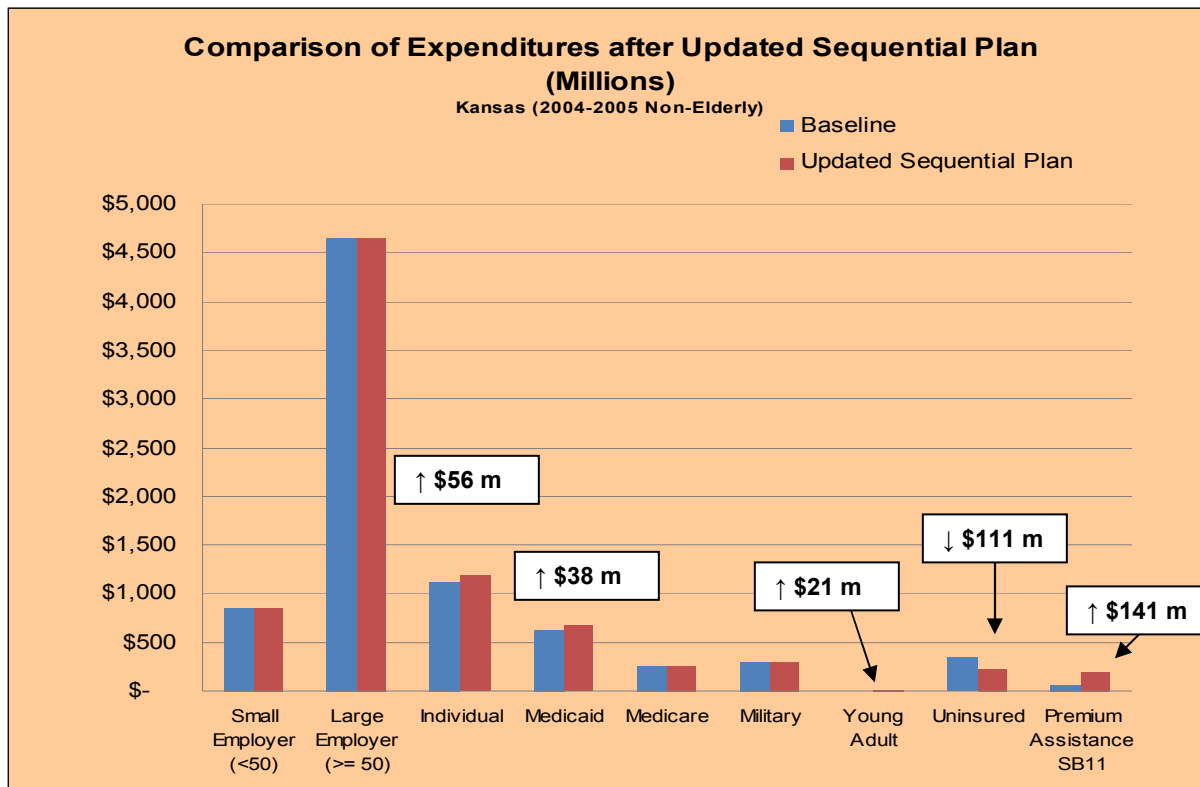


Figure 13

	Paid by State Government	Paid by Federal Government	Net Cost of Reform
<b><u>Children:</u></b> Targeted Outreach	+ \$14 million	+ \$17 million	+ \$31 million
<b><u>Young Adults:</u></b> Clearing House – YAP*	-.-	- \$9 million	- \$9 million
<b><u>Low Income Kansans:</u></b> SB 11 Expansion	+ \$56 million	+ \$63 million	+ \$119 million
<b><u>Small Businesses:</u></b> Clearing House – VSG*	+ \$1 million	- \$6 million	- \$5 million
<b>Total costs for Updated Sequential</b>	<b>+ \$71 million</b>	<b>+ \$65 million</b>	<b>+ \$136 million</b>

Figure 14



Note: Figure 14 includes an additional \$9 million in expenditures by other than the State or federal governments





# Financing Health Reform in Kansas

## FUNDING OPTIONS

States have considered a wide variety of funding options for their health reform initiatives. The funding approaches typically fall into four broad categories that are differentiated by the connection they make between the tax mechanism and the need or outcome of health care reform.

1. Lifestyle Taxes – links certain lifestyle decisions to the cost of health care and tax behavior that leads to higher health care costs. Thus, these taxes are typically used to justify the need for care reform.
  - Junk food tax
  - French fry tax
  - Sucrose tax
  - Soda/beverage tax
  - Vending Machine tax
2. Health Care Services/Provider Taxes — links funding of health insurance reform to use of health care services. These taxes are also typically driven by the need for health care reform.
  - Hospital surcharges/inpatient bill tax
  - Insurance Premium Tax
  - Managed Care/HMO Tax
  - Elective Procedure Tax
3. Broad-Based Taxes – all citizens of a state potentially benefit from health care reform. These taxes are typically justified by the overall positive economic outcomes associated with health care reform.
  - Sales Tax
  - General Property Tax
  - Payroll Tax
  - Income Tax
  - Upper-Income Tax
4. Reform-Specific Taxes – draw a direct line between the need for funding and the cost of the tax. These taxes are typically justified by the cost of health care reform.
  - Special Health Care District Property Tax
  - Pay or Play Taxes

Looking to two states' actual funding approaches is informative. Maine and Massachusetts, the two most mature statewide health care reform initiatives, took widely divergent approaches to funding. Maine took a unique, albeit extremely contentious, approach to funding its statewide health care reform initiative, Dirigo. Maine has funded its Dirigo program using an assessment on payers (insurance carriers, third-party administrators, and self-insured employers) based on the savings generated by the sweeping nature of the whole of the Dirigo reforms. Payers have vigorously opposed the amount of savings calculated each of the first three years, maintaining that they are unfairly bearing the burden of the Dirigo program.

Massachusetts used several sources to fund its health care reform. Massachusetts had a very large existing Uncompensated Care Pool (hospital surcharge) that it coupled with pay-or-play provisions and additional federal dollars. This unique combination of funding sources has so far allowed the state to move forward, although the potential additional funding through penalties for non-participation have yet to kick in and it remains to be seen if they will survive legal challenges.

Neither Maine's nor Massachusetts' experiences are unique, as experience from across the country show the funding of health care reform to be the most contentious portion of the health care reform debate. The lesson learned on funding from these two states' experience is that it takes a broad-based coalition of all the key stakeholders in the state to design a funding mechanism that can survive the inevitably contentious economic, political debate surrounding health care reform.

## KANSAS' HIDDEN TAX RATE

One of the key health insurance issues being debated as states consider health insurance reform initiatives is whether, and to what extent, Americans with health insurance coverage are paying for the cost of health care for the uninsured through a "hidden tax" that results from cost-shifting. In reality, as the Stanford University Hoover Institute explained in a recent analysis, the research to date is preliminary and lacks a solid research basis to determine the extent to which



there is a possible “hidden tax” due to a cost-shift<sup>15</sup>. Nonetheless, researchers and advocates of health care reform look to “hidden tax” and other similar methodologies to investigate the potential health care cost-shift to private insurers and health care providers to cover the costs of uncompensated care received by uninsured Americans.

The following should be considered when applying the hidden tax rate to understand the potential health care cost-shift to private insurers and health care providers to cover the costs of uncompensated care received by uninsured Americans.

- Use of State-Specific Data is Important – As discussed within this report, Kansas-specific data (percent and amount of unpaid care used by the uninsured) differ from national averages.
- Consistency in Data Definitions and Formula – Researchers do not agree on the data definitions or their applications in the formulas they use in calculating their hidden tax estimates. This is one of the primary reasons for such widely divergent estimates of the impact of cost-shifting and any potential hidden tax on the premiums of insured Americans.

Because the differences in hidden tax estimates stem from differences in methodologies and data sources, it is too preliminary to identify a singular methodology. As a result, we are estimating a hidden tax rate in the range of 1.7% to 6.7% for Kansas. However, this range, absent reform, is likely to increase over the next couple of years based on the decrease in Medicaid enrollment which will likely result in higher numbers of uninsured persons residing in Kansas.

### **COST CONTAINMENT RECOMMENDATIONS**

All states face the challenge of balancing health care needs with available resources.

According to the Kaiser Family Foundation (KFF)<sup>16</sup>, each year health related spending grows, often outpacing spending on other goods and services. The cost increases have a significant effect on the way households, businesses, and government agencies conduct their affairs. Among other things, health inflation puts pressure on businesses who offer insurance coverage to their employees, inhibits individuals from purchasing their own coverage, can be a major finan-

cial burden to families, and takes an increasing share of government budgets and taxpayer dollars. Although the US spends nearly double per capita any other industrialized country, it suffers from worse health outcomes. A focus on cost containment through wise investments in our health and health system and can improve the value of our health care dollar.

The State of Kansas has already implemented a number of policies aimed at cost containment, such as: including cost sharing for HealthWave (the State Childrens Health Insurance Program); increasing care management strategies through managed care; including a cap on non-economic damages in malpractice cases; and re-balancing the state's long-term care system by developing and expanding home and community-based services. However, more can be done to help restrain the growth of health care spending.

Under the three priorities of health reform, the KHPA Board has included policy recommendations with a focus on cost containment. According to the National Conference of State Legislatures (NCSL)<sup>17</sup> and the National Association of State Health Policy (NASHP)<sup>18</sup>, states can help to drive down health care costs by implementing policies that both improve health status, and invest in health system improvements.

### **P1 PROMOTING PERSONAL RESPONSIBILITY: POLICIES AIMED AT COST CONTAINMENT**

- Restructure insurance products to increase personal responsibility for health care; (NCSL) – includes recommendations aimed at sharing financial responsibility for the cost of care and personal responsibility for health status
- Require public posting of prices for specified common procedures and tests (NCSL); includes recommendations aimed at educating and empowering consumers through the health care cost and quality transparency project and improved health literacy
- Promoting consumer directed health care (KFF); includes recommendations aimed at consumer engagement in health through health care cost price and quality transparency, health literacy, and the premium assistance program



## **P2 PROMOTING MEDICAL HOMES AND PAYING FOR PREVENTION: POLICIES AIMED AT COST CONTAINMENT**

- Increase the use of electronic medical records and other information technology (KFF); includes recommendation for a state-wide CHR with e-prescribing and disease management components for enrollees in Medicaid, HealthWave, and the SEHP
- Reduce the use of emergency room visits for non-emergency care (NCSL); includes recommendations aimed at promoting a medical home and coordination of care in the Medicaid and HealthWave programs
- Reduce Medicaid cost-shifting by increasing Medicaid reimbursement to providers enough to pay actual costs (NCSL); includes recommendations aimed at increasing reimbursement for Medicaid prevention and primary care services
- Reducing variation and disparities in health care practices across regions and providers (KFF); includes recommendation to utilize a standardized health insurance card format for Medicaid, HealthWave, and the SEHP
- Continue to Promote Childhood Immunizations (NCSL); includes recommendations aimed at increasing reimbursement for immunization visits for the Medicaid and HealthWave programs
- Raise the state's tobacco and/or alcohol tax (NCSL); includes recommendation to increase the tobacco user fee and tobacco excise tax in Kansas in order to curb smoking, improve health outcomes, and help to fund expansions in access to health care services
- Ban cigarette smoking in all public places (NCSL); includes recommendation to ban smoking in all public places in Kansas
- Require daily PE for grades K-12 with a minimum of 30 minutes of moderate activity (NCSL); includes recommendation for increasing physical education in Kansas schools
- Require vending machines in schools to offer healthy foods and beverages or ban the sale

of unhealthy foods (NCSL); includes recommendations to limit unhealthy foods and beverages in Kansas schools

- Invest in good oral health (NCSL); includes recommendation to provide dental services to pregnant women on Medicaid
- Invest in prenatal care (NCSL); includes recommendation to provide dental services to pregnant women on Medicaid
- Invest in cancer screening and education (NCSL); includes recommendation for expanding cancer screening for the EDW program in Kansas

## **P3 PROVIDING AND PROTECTING AFFORDABLE HEALTH INSURANCE: POLICIES AIMED AT COST CONTAINMENT**

- Expand the state's child health program (NCSL); includes recommendation to increase enrollment in Medicaid and HealthWave through aggressive outreach and enrollment targets, with "triggers" for additional policy action, including the consideration of mandates for health insurance. This will help to enroll an estimated 20,000 children
- Maximize federal funding for services that are reimbursable through Medicaid (NCSL); includes recommendation to expand the Premium Assistance program for low income adults without children, which would provide health insurance to an additional 39,000 Kansans
- Change the financing of the "high-risk" or "uninsurable" pool to spread the costs over all employers (NCSL); includes recommendation to include re-insurance for the very small business market place. Reforms aimed at the small business market will provide affordable health insurance to an additional 12,000 Kansans
- Implement disease management in high-risk pools (NCSL); includes recommendation to develop reinsurance specifically for those with high cost illness and implement disease management programs



## SUMMARY

The goal of health reform is to improve the *health* of Kansans – not just health insurance or health care – but the *health* of our children, our families, and our communities. To do that, our lens must be broad and our commitment must be long term. After many months of reviewing health reform options and meeting with over 1,000 Kansans, the Kansas Health Policy Authority (KHPA) Board voted to recommend to Governor Kathleen Sebelius and the Kansas Legislature a significant, pragmatic package of health reform recommendations that can be implemented now. These 21 reforms, taken together, provide a steady foundation to improve our health and health system – while beginning to control the unsustainable cost of health care – through increased personal responsibility; promoting prevention and medical homes, and improved access to affordable health insurance.

As we listened to Kansans all across the state, the issue of personal responsibility for health was mentioned over and over again. The KHPA reforms target the need for personal responsibility by embracing healthy lifestyles; making smart, cost-effective use of the health care system; and asking shared financial responsibility so that everyone is contributing to the cost of the health care system based on their ability to pay. Embracing wellness and prevention in families, schools, workplaces and communities helps to control health care costs in the long run, but is also key to improving Kansans health outcomes. Making informed health care decisions requires that Kansas consumers have access to basic health information that empowers them to make appropriate health decisions. Also, because current health information is complex and difficult to understand, improving health literacy will help to ensure that consumers better manage their health care and medication regimens -- resulting in improved health outcomes and fewer emergency room visits. Finally, asking consumers to contribute to their health insurance coverage – based on their ability to pay – helps to increase awareness of, and investment in, prudent health care purchasing decisions. Effective purchasing, however, requires that we provide useable information that facilitates consumer understanding of when and how to seek health care.

Kansans also weighed in on how difficult our health care system is to navigate – especially for those who are chronically ill. Research suggests that better

health outcomes are associated with care that is coordinated through a “primary care medical home” – meaning that all members of a family receive services that are respectful of, and responsive to, individual patient preferences, needs, and values and coordinated through a primary care provider. According to recent research, children and adults who have easy access to a regular health care provider are more likely to adhere to prescribed medications, receive better preventive care, and are less likely to visit the emergency department and be hospitalized. In addition, the provider is more likely to recognize their patients problems and track their information. Having all family members as part of the same health insurance plan also helps to coordinate care. In this sense, medical homes are the foundation of patient (or person)-centered care, designated by the Institute of Medicine as one of the six aims for an improved US health care system.

Finally, Kansans almost unanimously voiced their concerns about the rising cost of health insurance in our state. The KHPA Board members voted to improve access to affordable coverage through policies that focus on children and young adults, low income Kansans, and small businesses. The KHPA Board continues to strongly support access to care for all Kansas children – and as a first step, supported aggressive outreach and enrollment of eligible children, setting a target of adding 20,000 eligible Kansas children to the Medicaid and HealthWave programs. Targeted insurance market reform will help 15,000 young adults (age 19-25) get access to affordable health insurance. One of the health insurance reform policy options would pay for private insurance coverage for adults without children who make less than \$10,210 a year. This will insure an additional 39,000 Kansans who are uninsured today. Another policy option would help solo business owners and very small businesses with the administration and paperwork involved in providing health insurance; encourage employees to purchase health insurance with before-tax dollars; and help to stabilize the small business insurance market. These policies would insure an additional 26,000 working Kansans and their families. All told, these policies which are focused on those most in need would increase the number of insured by 86,000, ranking Kansas near the top among states for the lowest percentage of uninsured.



In advancing these recommendations to the Governor and legislature, the KHPA Board focused on improved health for Kansans, first and foremost. We hope that this health reform package -- with recommendations for promoting personal responsibility, encouraging prevention, and advocating the use of medical homes, together with significant improvements in access to health insurance -- offer meaningful, actionable health reform. We respectfully submit them to our elected leaders and stand ready to be a resource as they debate critical policy issues to improve health for all Kansans.

**APPENDIX A: FIVE ORIGINAL HEALTH REFORM OPTIONS**

**A1—DESCRIPTION**  
**A2—POPULATION AND EXPENDITURES COMPARISON**

**KHPA Board Members:**

Garen Cox	CEO, Medicalodges Inc.
Ray Davis, PhD	Dept of Public Administration, University of Kansas
E.J. (Ned) Holland, Jr	Senior Vice President, Human Resources, Embark Corporation
Connie Hubbell, Chair	Senior Vice President, Kansas Foundation for Medical Care
Rob Kaplan	Professor of Management Practice, Harvard Business School
Arneatha Martin	Faculty, Wichita State; CEO and Co-Pres for the Center for Health and Wellness (retired)
Vernon Mills, MD	Pediatrician
Susan Page	CEO and President of Pratt Regional Medical Center
Joe Tilghman	Regional Administrator, Center for Medicare and Medicaid Services (retired)

**Ex-Officio Members**

Kathy Greenlee	Secretary, KS Department on Aging
Roderick Bremby	Secretary, KS Department of Health and Environment
Don Jordan	Secretary, KS Social and Rehabilitation Services
Duane Goossen	Secretary, KS Department of Administration
Sandy Praeger	Commissioner, Kansas Insurance Department
Howard Rodenberg, MD	Director of Health, KS Department of Health & Environment
Marcia J. Nielsen, PhD, MPH	KHPA Executive Director



## **APPENDIX A1: FIVE ORIGINAL HEALTH REFORM OPTIONS: DESCRIPTION**

The following health insurance reform options were modeled and discussed at KHPA Board meetings and were instrumental in the development of the Updated Sequential plan. A complete report can be found at the United Methodist Health Ministries Fund website ([www.healthfund.org](http://www.healthfund.org)).

### **1. REFERENCE OPTION**

Voluntary expansion of public programs to cover children and adults, regardless of family status up to 250% FPL (\$48,375 annually for a family of four in 2005). Administration and delivery would piggyback on the current system with benefits matching current Medicaid or HealthWave levels and utilizing the same delivery network. The Reference Option would require include:

- obtaining federal approval so expansion costs can be shared between the state and federal governments, and
- dealing with crowd-out: some portion of this newly enrolled individuals in this population chose to forgo private insurance and opt for public coverage

### **2. AFFORDABLE COVERAGE OPTION**

Voluntary individual and small group market reform. It would merge the individual and small group markets. It would require:

- community rating and guarantee issue to ensure uniform coverage access,
- access to Section 125 to open up tax benefits for offering insurance to more companies, and
- moderation of risk from any single policy or policyholder through public subsidization of a reinsurance program.

Additionally, the option creates an insurance clearinghouse for the combined market to provide review and approval of products and provide assistance to employers seeking Section 125 tax benefits.

### **3. UNIVERSAL COVERAGE OPTION**

Mandatory health insurance reform through individual and employer mandates. It would establish a pay or play mandate for all Kansans. It would require:

- all individuals to have, and all employers to offer, health insurance,

- access to Section 125 to open up tax benefits for offering insurance to more companies
- moderation of risk from any single policy or policyholder through public subsidization of a reinsurance program.

The option would be built on the existing employer/carrier marketplace with an added infrastructure to establish and maintain an insurance mandate provide assistance to employers seeking Section 125 tax benefits.

### **4. THE MOUNTAIN (SINGLE PAYER) OPTION**

Requires all Kansans receive health insurance through the Kansas Health Insurance Program, a newly established statewide health insurance program responsible for all health insurance in Kansas. It would create a single-payer for all health insurance in Kansas. It would require:

- community rating and guarantee issue to ensure uniform coverage access,
- establishing a compliance/exemption process with affordability set at 10% of income, and
- creation of state-controlled benefit package and reimbursement schedule.

### **5. SEQUENTIAL OPTION**

The Sequential Option is a three-part health insurance reform option with both voluntary and mandatory components (Figure B1-5.1). It would require:

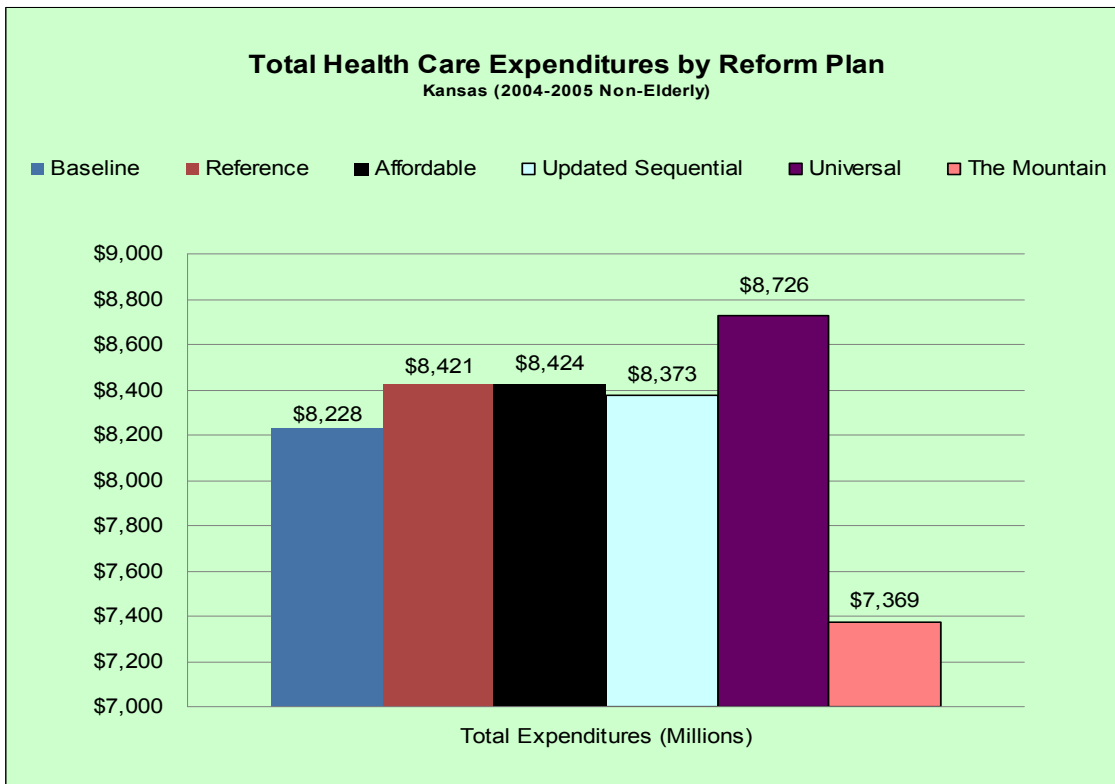
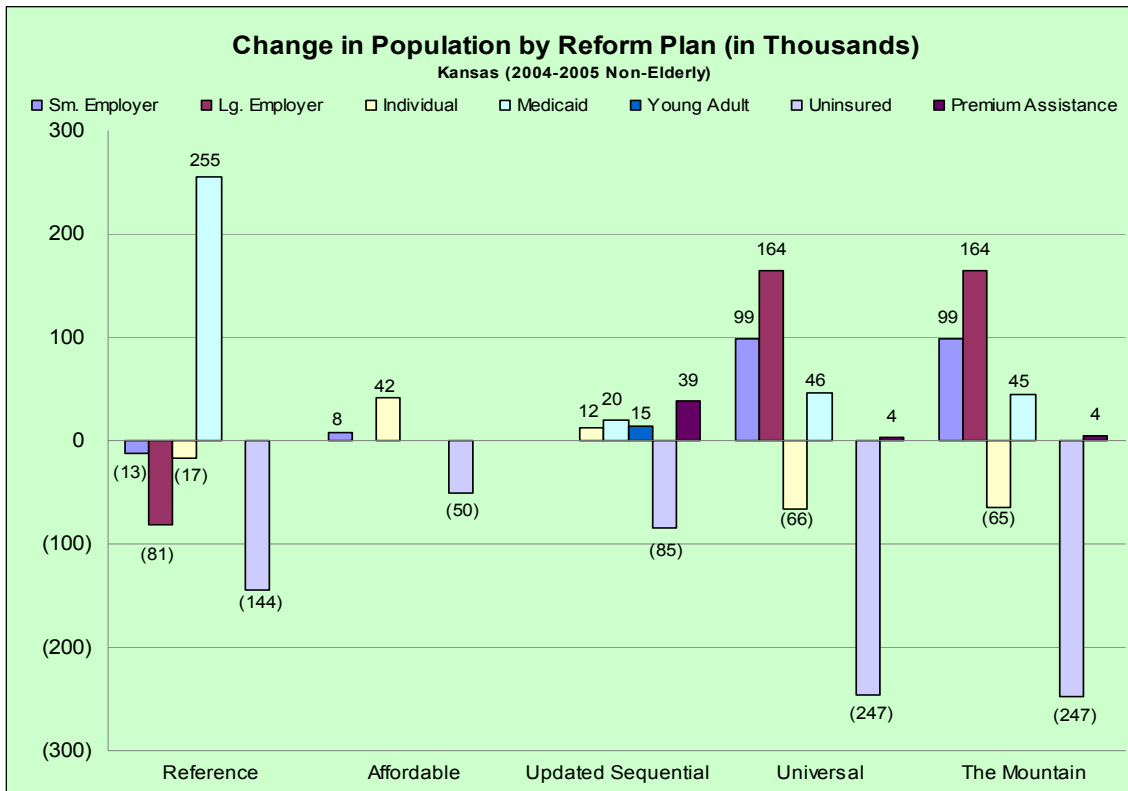
- mandatory insurance for children up to age 19 years old
- expanding SB 11 premium assistance up to 150% for childless adults, and
- creation of a connector/exchange, modeled after the Business Health Partnership to be an insurance market clearinghouse.

The children's mandate would be enforced by requiring all children to show proof of insurance prior to enrolling in school. The connector/exchange would have several components; require all employers provide access to Section 125 plans, combine the sole proprietors and small group markets into a single market that spreads the risk through a subsidized reinsurance program and a mandatory go-bare provision of at least six months (employers would have to demonstrate that they have not had health insurance for the last six months).





## APPENDIX A2: FIVE ORIGINAL HEALTH REFORM OPTIONS— POPULATION AND EXPENDITURE COMPARISONS



## NOTES

- <sup>1</sup> Commonwealth Fund 2007; State scorecard of health system performance across dimensions
- <sup>2</sup> Excerpts from Value Driven Health Care Home Initiative; US Health and Human Services Secretary Michael Leavitt; <http://www.hhs.gov/valuedriven/index.html>
- <sup>3</sup> Excerpts from National Network of Libraries of Medicine; <http://nnlm.gov/outreach/consumer/hlthlit.html#A1>
- <sup>4</sup> Institute of Medicine. Health Literacy: A prescription to end confusion. April 2004
- <sup>5</sup> Excerpts from "Schoenbaum, S., Davis, K., Abram, M. No Place Like Home. *Commonwealth Fund*. Dec. 19, 2006"
- <sup>6</sup> Commonwealth Fund 2007; State scorecard of health system performance across dimensions
- <sup>7</sup> Excerpts from American Hospital Association (October 2007) Healthy People Are Nation Foundation. Original document, including citations <http://www.aha.org/aha/research-and-trends/AHA-policy-research/2007.html>
- <sup>8</sup> National Center for Health Statistics. Mortality Report. Hyattsville, MD: US Department of Health and Human Services; 2002. Also, adapted from McGinnis Foege, up dated by Mokdad et al.
- <sup>9</sup> Schroeder SA. New England Journal of Medicine 2007;357:1221-1228
- <sup>10</sup> Excerpts from the Commonwealth Fund website for the Program on the Future of Health Insurance. Available at [http://www.commonwealthfund.org/programs/programs\\_list.htm?attrib\\_id=11934](http://www.commonwealthfund.org/programs/programs_list.htm?attrib_id=11934)
- <sup>11</sup> Kansas Department of Insurance. Excerpts from the State Planning Grant Findings for 2001. Other reference materials located at <http://www.ksinsurance.org/>
- <sup>12</sup> Kansas health insurance statistics were collected from the Annual Social and Economic Supplement to the Current Population Survey available at <http://www.bls.census.gov/cps/asec/adsmain.htm>
- <sup>13</sup> Excerpts from the Mercer Uninsured Report: State of Kansas. July 7, 2005
- <sup>14</sup> Wellever, A. 2003. Statewide Survey Highlights Health Policy Concerns of Kansans. Kansas Health Institute. Number 16; October, 2003.
- <sup>15</sup> Excerpts from Nichols, Len and Peter Harbarger. 2007. *ESTIMATING THE "HIDDEN TAX" ON INSURED CALIFORNIANS DUE TO THE CARE NEEDED AND RECEIVED BY THE UNINSURED*. New America Foundation. Health Policy Program: Policy Memo. May 21, 2007.
- <sup>16</sup> Kaiser Family Foundation. Health Care Costs: A Primer. Key Information on Health Care Costs and Their Impact. August 2007
- <sup>17</sup> National Conference of State Legislatures. State Health Care Cost Containment Ideas. Prepared by NCSL's Standing Committee on Health. Final Draft : July 2003
- <sup>18</sup> National Association of State Health Policy. Rising Health Care Costs: State Cost Containment Approaches. June 2002

